

The Boston Medical and Surgical Journal

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Address.

THE PHYSICIAN AND THE SURGEON.*

BY HARVEY CUSHING, M.D., BOSTON.

"Why, in God's name, in our days, is there such a great difference between the physician and the surgeon? The physicians have abandoned operative procedures to the laity, either, as some say, because they disdain to operate with their hands, or rather, as I think, because they do not know how to perform operations. Indeed, this abuse is so inveterate that the common people look upon it as impossible for the same person to understand both surgery and medicine. It ought, however, to be understood that no one can be a good physician who has no idea of surgical operations, and that a surgeon is nothing if ignorant of medicine. In a word, one must be familiar with both departments of Medicine."

"No one can be a good physician who has no idea of surgical operations, and a surgeon is nothing if ignorant of medicine." This, Gentlemen of the College, is my chosen theme, and lest you think it a novelty of my own, I hasten to add that the paragraph quoted is transcribed from writings which exist for us only in manuscript, since Lanfranchi, called the father of French surgery, who expressed this sentiment, lived two centuries before Gutenberg.

When one considers the healthy unification of Hippocratic medicine, why was there such

a difference in Lanfranchi's time, and must we admit that the difference he lamented still exists in ours? Does the shadow of the mediaeval schism dividing medicine and surgery, and both from the church, which originated, history tells us, in a thirteenth-century papal decree forbidding the participation of the clergy in any procedure involving the shedding of blood—does the shadow of this schism still lie upon us? What difference, after all, is there between physician and surgeon except in the kind of cases each of them chooses to treat and in the variety of therapeutics applied? And in view of many centuries of separation, do we tend toward reunion or further separation? These are questions which concern in no small degree the very existence of this College.

THE PHYSICIAN'S PROGRESS.

We certainly have stumbled along widely divergent therapeutic ways, we lay physicians and lay surgeons. The great physicians of ancient days were first of all given over to a polypharmacy inherited from the Arabians, then to the Law of Signatures with its astounding botanical therapeutics, then to a period of heroic bleedings and purgings and sweatings. Homoeopathy followed, and taught the profession a much-needed lesson, and finally cellular pathology and bacteriology came to revolutionize physic by arousing a profound skepticism in regard to the efficacy, whatever the dose, of most of the drugs abundantly prescribed for symptomatic purposes. This gave to the tradi-

* Presidential Address before the American College of Surgeons, Boston, October 27, 1922.
F.C.C. Henry E. Browne's *Gilbertus Anglicus*, privately printed. The Cleveland Medical Library Association, 1918, p. 77.

tional practices a staggering blow, and the coal-tar products with synthetic chemistry finally closed the physic-garden, drove plants, with a few notable exceptions, from the pharmacopœa, and Botany from the curriculum.

While all this was going on, much time was spent in evolving "systems" of therapeutics based upon bizarre interpretations of pathology which followed one another in succession, the Brunonian doctrine being one of the last, whereby diseases were either sthenic or asthenic; and a century and a half later we still hear "asthenic states" spoken of as ones which need supporting treatment by alcohol, so that even in these dry days the physician is privileged to prescribe the drug that was Brown's personal undoing, though he lived north of the Tweed.

It is an old saying that the wisest physician is he who knows the uselessness of the most medicines. Nevertheless, in an unfortunate alliance with the apothecaries, at about the time the surgeon was entangled with the barber, the eighteenth-century physician was accustomed to write prescriptions for patients he hadn't seen, while enjoying good company in the coffee-house. Some measure of common sense in matters therapeutic was finally knocked into the profession by the growing appreciation of the self-limitation of many diseases, by the success first of Hahnemannism, and later of other cults like Mother Eddy's, which revived the therapeutic importance of a neglected principle well known in the Aesculapian temples—the influence of the mind upon body ailments, particularly when imaginary in large part, as so many of them are. Mr. Dooley once sagely remarked that "if the Christian Scientists had a little more science and the doctors more Christianity, it wouldn't make much difference which you called in—provided you have a good nurse." And there is no doubt but that Florence Nightingale and her successors have also had much to do with modifying our modern therapeutics.

But the profession has not entirely regained its therapeutic sanity under these benign influences. Those uncritical and poorly trained physicians who live in glass houses and give welcome to the prescriptions of certain pharmaceutical establishments which elbow their way to our desks on leaflets and postcards, cannot throw stones at the laity who give no less a welcome to nature-healers, herbalists, chiropractors, bone-setters, patent-mediciners, and other charlatans beyond enumeration. Little wonder that the wiser heads, both lay and professional, have about come to the conclusion that we had better limit the number of students in our schools, and let a smaller number, better trained, devote themselves to the prevention of disease, and, through public-health measures, keep the bulk of the community well in spite of itself, in much the same way that we protect our livestock.

THE SURGEON'S PROGRESS.

While all this has been going on through the centuries, in physic, the surgeon was pursuing an entirely different way, independent of tradition, and, for the most part, be it said, in rather bad company. A handicraftsman, often a rude, uncultivated, and ignorant though practical fellow of itinerant proclivities, he was rarely utilized in the schools, and when so employed, merely as the tool of the more learned and socially more respected physician. He had broken away from established authority; he ventured to write in the vernacular, and sometimes to operate without the physician's permission. Indeed, he did many unorthodox things. However, he was greatly needed, especially in time of war, as Charles V used Vesalius; as four successive Bourbons used Paré; Elizabeth, William Clowes; Charles I, Richard Wiseman; and, to give an example from more modern times, as Napoleon used Larrey. Thus he came to be respected at court, even though he was kept out of the faculties, where he was looked upon with scorn not untinged with jealousy. An outcast both of church and profession, he finally climbed into professional and some measure of social esteem about the middle of the eighteenth century by way of the barber-pole. But his long and quarrelsome alliance with the Guild of Barbers, humiliating enough, was peaceful when compared with the quarrels of the physicians and apothecaries.*

A short century after the surgeons succeeded in breaking away from this alliance with "barbery" and were readmitted into the schools on the same footing as the physician, there came Lister on the heels of Pasteur, to revolutionize, not only surgical therapeutics, but, at the same time, by the introduction of surgical cleanliness, the very hospitals in which both physic and surgery are practised. And so it has come about that while the physician today has busied himself in perfecting elaborate methods of diagnosis for many chronic disorders, he rather shrugs his shoulders over therapeutics; whereas, on the other hand, treatment by operative methods has developed amazingly, and there is no gainsaying that in the hands of some it tends to run away with itself as a therapeutic measure.

REUNION OF PHYSICIAN AND SURGEON.

Thus, in very rough outline, the two main

* Sir William Stokes in an article entitled "The Altered Relations of Surgery to Medicine" (Tr. W. Lond. Medico-Chir. Soc., 1888, iii, 126-7), wrote as follows:

"... In the interests not only of the social, but also of the scientific position of the surgical profession, the injunction, such as it was, of these two corporations (the Surgeons' and the Barbers' Company) was undoubtedly a calamity, and it helped to give the physicians the vantage-ground which they occupied so long, and in which they were still further strengthened by an enactment made in Elizabeth's reign prohibiting surgeons from prescribing internal medicines. As a proof that the inferior position, socially and scientifically, was maintained up to a comparatively recent period, I may mention as a fact which I learned from Mr. Colles, who informed me that his father, Abraham Colles, had stated that at the commencement of his professional career in Dublin, when a consultation on any important case was held, the surgeon was not as a rule permitted to be in the room where the physicians held their deliberations, but, after the consultation was over, he was informed whether his services would be required or not."

clinical branches of Medicine, long separated both socially and professionally, have grown in ways so divergent that the fact of their origin from a common stem has become obscured by an accumulation of therapeutic débris left by a succession, on the one hand, of theorists who, like the modern endocrinologist, may perhaps see the patient as a whole, but through a mist, and by the modern surgical specialist who sees only a part, but that part so disproportionately he is tempted to remove some of it.

Should these therapeutic groups be allowed to riot in their growth unmolested, branching in all directions at will, or will they bear better fruit if grafted or fertilized or cut back remorselessly? All agree that the time is at hand at least for some judicious pruning, both in physis and surgery, and for the removal of sufficient rubbish to permit the main stem of Medicine and its roots of Science to be properly exposed and aerated. This process will be good for both root and branch, but more particularly will it benefit the branches if it has the effect of making the surgeon less of a pure technician and more of a physician, and the physician more capable of utilizing some of the minor procedures of surgery and with a better understanding of the major ones.

"In a word, one must be familiar with both departments of Medicine," and this is no less true today than in the thirteenth century or in the days of Hippocrates. By no means did Lanfranc, in the statement which has been quoted, mean to imply that physicians must practise surgery—merely that they will be the better physicians the better their understanding of surgical therapeutics; and, on the other hand, that no surgeon should be regarded as qualified to undertake operative procedures who is not primarily and thoroughly grounded in medical diagnosis. A graduate in Medicine may have a very wide knowledge of surgery or even be a successful teacher of the subject without necessarily being himself an operator, just as one may have a thorough knowledge of music without being a performer. So, also, there may be many activities in which a physician may engage, beneficial to his profession, without necessarily "practising" or prescribing drugs.

However, when in common parlance we differentiate physician and surgeon we do so only on the basis of therapeutics, and, granting the same underlying knowledge of disease, this is all that separates, from Medicine proper, homeopathy and osteopathy and all the other therapeutic cults, each of which reaches some degree of sanity so soon as it undertakes to perform surgical operations, as in time it is inevitable each one of them should do. There is nothing homeopathic about the scalpel, and when surgery was permitted to creep into this doctrinaire school it was near its end. The osteopath and chiropractor and eclectic and all the others

may beware of this, for so soon as they come to engage in surgery, then a thorough medical grounding will be necessary, so that the natural end of all such cults is, that, dead or alive, they will become swallowed in time by the general profession, distasteful as the dose may be.

METHODS OF TEACHING.

Unquestionably, what chiefly influences the direction of its growth is the way in which Medicine as a whole is taught—the way in which its various subdivisions are presented to the student, and the relative stress laid upon them. Whatever their spirit of altruism, most of our students enter the profession as a means of livelihood, and are likely to be influenced by what seems to them, given an ordinary degree of ability, to be the most likely road to an income-producing end, whether it be as a laboratory worker, or public-health official, or physician, or surgeon, or specialist of any sort. A disproportionate amount of teaching, or better and more personal teaching in one subject over another, whereby the student's interest is aroused and he begins to feel a certain amount of confidence in his knowledge, will inevitably lure in that direction the larger number.

The periodical turnover in our curricula is an evidence of the fact that faculties show a perennial dissatisfaction with existing conditions, and strive each of them to find the proper average allocation of subjects, little realizing that it makes no great difference—that the fault lies with us the teachers, not with the curriculum, for Medicine can be successfully taught from many angles if only students are properly stimulated and encouraged to observe and think and do for themselves. But what has become particularly apparent of late is that the curricular tree has become overloaded by grafting upon the clinical branches an undue profusion of specialties, few of them of fundamental importance even though they doubtless bear fruit of marketable value which dangles before the student's eyes so alluringly that he is prone to forget, or to overlook entirely, the source of origin of the specialty in general Medicine.

There has been a great reaction against this, and our supposedly more progressive schools are engaged in lopping off a number of these clinical branches. Some schools, indeed, have come to pay so much attention to the root and stem that, if we do not beware, the top will be cut back so far that there will be neither foliage nor fruit—no medical practice whatsoever—and thereby encouragement will be given to the growth of every conceivable form of quackery, which will spring up around us as have the schools of the chiropractor, to fill the depleted ranks of the profession; and the indifferent public is probably worse off than it was before. Far better than this would it be for us to send out after two years of clinical study alone, with some additional knowledge of public

health, a group of men to be licensed as Bachelors of Medicine, who at least could attend to the ordinary ailments and health of the rural districts, where public opinion is largely made and from which legislation, detrimental or otherwise to the interests of the profession in its campaign for sanitary measures, is likely to emanate.

TEACHING WITHOUT THE PATIENT.

It is a curious commentary on our methods, that, while we have come to emphasize the importance of teaching the pre-clinical sciences by practical laboratory exercises so that the student may at least have some first-hand knowledge of the scientific method and may learn to interpret and observe for himself, we have tended, if not to abandon, at least to postpone to the end of the course, these very methods so far as the clinic is concerned. To be sure, we have long outgrown the time-honored quiz as the basis of teaching, than which nothing could have been less practical. A student may know his textbook thoroughly—may, for example, give without hesitation, when asked for them in an examination, all the symptoms of that vanishing disease, typhoid fever; but if he has to utilize his own observation, senses, and wits, and dig out, himself, the essential symptoms and signs which make the diagnosis possible, he is so incapable of reversing his acquired mental processes that the idea of typhoid fever never enters his bewildered head. Only by prolonged contact with the patient at the bedside can he come to take a good history, to make a proper examination, to learn to separate the wheat from the chaff of the patient's complaints; all of which must precede the interpretation and the treatment of the existing disorder.

The so-called case system of teaching has become highly developed and popularized in certain schools—a diagnostic exercise whereby, through the process of elimination and logic, the predigested data acquired by a variety of people are presented for discussion and analysis. Such a method is excellent for training in the law, since in the legal profession one argues on the basis of authority and accumulated testimony, in accordance with which satisfactory judgments can be rendered and punishments meted out without even seeing the culprit. But the medical profession has long since broken away from dogma and authority, and though the case system, given a lively instructor, provides an interesting exercise in medical diagnosis far superior to the old-time quiz, when carried far it has the great danger of making logicians of the students, rather than practical physicians. There is some danger lest the student be led to feel that it is unnecessary, for a diagnosis, to examine the patient oneself—someone may get the history, another make a physical examination, still others supply the x-

ray findings, the laboratory tests, and so on, while all that the modern physician needs to do is to sit and expound, as did the mediæval anatomist while the barber did his dissections for him. Excellent as they may be, there is nothing practical about such exercises, and if over-emphasized they are bad for both teacher and student. For the teacher because he gets out of the habit of making his own thorough examination of the patient; for the student, who gets an impression that the diagnosis, which an autopsy may confirm or otherwise, is the only thing of importance, and treatment for the most part futile. Meanwhile the patients in their homes, in the dispensary, even those in the wards, would like to know what these professors who admittedly are having difficulty in telling, without looking at the organs, what certain people died from, are going to do to relieve their individual backaches or troublesome coughs—and perhaps it would be just as well to go to a chiropractor next time. Indeed, it takes a good deal of explaining to make clear that a lumbar puncture, bismuth studies under the fluoroscope, a blood-urea examination, metabolism observations, Wassermann tests and electrocardiograms made by as many different people, most of them technicians at that, each in their several laboratories—that all these things are necessary preliminaries to the recognition of his malady. All too often, alas, the knowledge thereby gained fails in any way to make him more comfortable or to prolong his expectation of life. The patient submits to all this and is very glad to know, in the abstract, that diagnosis has become a laboratory science which employs the modern principle of piece-work, and that the medical profession looks forward to the prevention of many existent diseases from which posterity will be exempt—but “meanwhile, doctor, what can you do to relieve my present discomforts so I may get back to work?” He is inclined like the Irishman to ask, “What has posterity ever done for me?”

THE HOME-TRAINING IN MEDICINE.

The curriculum in all of our schools still retains one essentially practical clinical course to which attention may be drawn—a course forced upon us by Boards of Registration, else even this might be curtailed or lost. It exists in the case of obstetrics, for no student is allowed to get his degree unless he has actually, himself, supervised a certain number of confinements. Here is an actual test of the medical novice's resources, the one practical test of what he may be able to do in a possible emergency in a patient's home. Nor would any of us wish to see the students robbed of this invaluable experience. On the contrary, it would be an admirable thing if the principle could be extended and every student, before his graduation, required under the control and supervision of his teachers or the district physician of the community, to engage in an actual house-to-house practice.

armed perhaps with nothing more than a clinical thermometer, a stethoscope, his fingers, and wits, supplemented perhaps by a microscope and a few anilin dyes. In this way he might learn something at least of the living conditions which modify the health of the people he now only meets in the dispensary, surrounded by all of the paraphernalia and instruments of precision supposed to be necessary for a diagnosis. It is a leaf one might take from the book of certain of the training-schools for nurses whose candidates must prove their capacity to engage in actual home-practice before they can qualify for a degree. One of our highly trained young physicians, long-time resident in a teaching hospital, recently confessed to me that he had just been through one of the most valuable experiences of his ten years of medical study. He had passed his summer on an island where was a large summer community, and in the absence of any local physician he had volunteered to hold office hours and prescribe for the needs of his fellow-sojourners, his principal armament being a thermometer, his microscope, some bandages and a few simple drugs. Never before had his powers of observation and his common sense been so thoroughly exercised.

THE SURGEON IN OTHER COUNTRIES.

It is a curious anomaly that the British surgeon, taken as a whole, is probably in practical ways a better trained physician than is the American surgeon, and yet he rarely possesses a full medical degree, and is apt to pride himself on not being called a doctor. Here, on the contrary, the surgeon, though graduated a Doctor of Medicine, not infrequently lapses into the state of being little more than a craftsman who, except for the external parts of the body, makes little or no pretence at diagnosis but expects the "internist," often without any expression of an independent judgment, to show him the way.

Different countries—indeed, different parts of the same country—vary greatly in the attitude of physicians or surgeons toward their problems. An illuminating experience of this past summer, during an all-too-short service as *locum tenens* for Mr. George Gask at St. Bartholomew's Hospital, has left me with the impression that the British student gets a more practical clinical course based upon far better training in anatomy and gross pathology than do most of our students, and that he is far less inclined to lean upon laboratory accessories in making his diagnosis. He, for a longer time and more intimately, is brought in contact with the ninety per cent. of human ailments upon which complicated laboratory tests have no special bearing, and through practical experience is apt to arrive at a reasonably sound conclusion in regard to his patient's disorder, and have a shrewd idea of the appropriate form of treatment. True, he may miss some of the more rare conditions, for which, after all, little can be done therapeuti-

cally—conditions which our students, with their vastly better laboratory facilities, might recognize in all likelihood. But, should we put side by side at work in a small town the average product of these two methods of teaching, I am inclined to think that the former would be the more resourceful, and exercise greater wisdom though possessed perhaps of less learning. And, after all, the strength of a profession, as of a nation, is represented by its average product.

CARE OF THE MINOR AILMENTS.

One looks in vain in the curriculum for a course on the common-sense treatment of minor ailments. It has been said by a wise and philosophical lay observer of the profession that so far as he can see, the only difference between the so-called "practical" doctor and the "scientific" one who has had a thorough laboratory training, is that the latter is more likely to cure his patients. But with all personal sympathy for this point of view, the community, particularly its rural portion, still has an enormous need for the common-sense practitioner, who for his four undergraduate years, under careful supervision, has seen less of complicated laboratory methods and more of the handling of sick people afflicted with the common everyday minor injuries and maladies. Otherwise we shall utterly abandon this all-important work to quacks and charlatans, who may become very skilful at it, in spite of their chicanery. I am not at all sure but that, for most of our schools, some measure at least of the French system would be best, whereby from the very outset of their course medical students are brought in direct contact with patients, and the laboratory courses are given conjointly and possibly prolonged throughout the four years.

We must somewhere and somehow strike a middle ground between over-training in the laboratory and under-training at the bedside, or the reverse. Certainly at the present time our graduates—many of them at least—no longer feel that the rôle of the country doctor, or even the general practitioner in the town or city, is at all an alluring one, even a possible one, so dependent have they become on complicated laboratory findings in arriving at a diagnosis. Unquestionably, there is an economic element which also enters into this, for a training in Medicine at the present day is unduly long and expensive, entirely disproportionate to any possible returns to be gained from a rural practice.

STRESS UPON BIOLOGY RATHER THAN ANATOMY AND PATHOLOGY.

Unquestionably, the present stress laid in this country upon the pre-medical laboratory courses, particularly those in chemistry and physiology, has greatly influenced the entire point of view of the physician, who must have a calorimeter and an electrocardiograph with a technician to operate them, if only to keep in fashion, little

realizing that they are scarcely more than research instruments. There has been much talk about the modern physiological schools of physic and surgery, and I presume this means that it is less fashionable for the clinicians to grub in the pathological and anatomical laboratories than formerly. No doubt this is the case. Anatomy and pathology just now appear to the unimaginative to have been thoroughly explored; the pioneers have taken the surface washings, and rather than dig deep for gold we prefer to look elsewhere for novelties and chance findings.

The interest of the students in these two particularly essential subjects has unquestionably flagged, for they naturally reflect the attitude of their teachers. I know no better illustration of this than the fact observed in many hospitals, that the physician is less apt than formerly to follow his patients to the operating room, and appears to be less eager than in days gone by to have a view, during life, of the pathological lesion. His place there has been taken by the radiographer who is more often on hand to see his diagnoses confirmed or otherwise. This may be for the reason that the disclosures at the operating table relate to regional pathology, and the surgeon rarely exposes lesions which will enlighten those interested in blood urea, the Wassermann reaction, calorimetric or electrocardiographic estimations.

THE PHYSICIAN-SURGEON.

Does this not mean that the surgeon has become the internist, or, put another way, that the internist (as the physician was once called) has come to do his own surgery? If this be so, it behooves the surgeon to accept the fact that he must be, primarily, a good physician—and the physician, loath as he may be to admit it, that he has undergone a metamorphosis. A year ago this College gave an honorary fellowship to the Professor of Medicine of the University of Stockholm, who had evolved an operative method, entailing great skill, whereby the adherent lung may be completely collapsed in the treatment of pulmonary tuberculosis. A distinguished member of this College, whose name we perpetuate by an annual oration, first conceived the idea of putting the diseased lung to rest, but it remained for Professor Jacobaeus, a physician, to add a further and important step to the procedure by the intrathoracic division of pleural adhesions—a step which had not been undertaken even by so imaginative and radical a surgeon as was John B. Murphy.

This, indeed, was a very significant and unusual occurrence, but, properly interpreted, the giving of this fellowship was merely an admission of the successful invasion of the surgical field by one who occupies a Chair of Medicine, and the prompt recognition of his contribution by the surgeons. Similar therapeutic invasions of what was once "internal medicine" have been made by those who because they handle a scalpel,

and are willing to set broken bones, are called surgeons, with no corresponding recognition, so far as I am aware, by societies of physicians.

There are, however, certain exceptions in the case both of individuals and of special societies—men who without disrespect are called Surgeon-Generals of Army, Navy or Marine Corps, are apt to hold membership in societies both of physicians and surgeons, even though, like the lamented Gorgas, they may be essentially sanitarians—societies, too, which recognize the inadvisability of confining their numbers to those averse or otherwise to a participation in surgery. The neurologists, for example, have opened their membership to so-called neurosurgeons, to the unquestioned benefit of those who do, and those who do not, care personally to employ operative methods of treatment. It has made the surgeons strive to be better neurologists, and given the neurologists a better conception of what therapeutic contributions their surgical colleagues are capable of making. It enables both groups better to keep their feet on solid ground, and there is no danger that the society will ever become so overrun by the surgeon as to let operative therapy fly away with itself and jump over the moon.

TENDENCIES IN PHYSIC AND SURGERY.

May I indicate the direction of our present drift, as physicians and as surgeons, by citing two recent examples from my own clinic—they are doubtless extreme examples but they will serve my purposes. Patient Number One was referred for diagnosis from a sanitarium which she had entered because of headaches, and where she had had a long and expensive sojourn. She brought with her a sheaf of records detailing special studies, made by different people, on her blood (even to the coagulation time), cerebrospinal fluid, stools, fields of vision, metabolism, alveolar air and carbohydrate tolerance. It was an impressive array of findings, all within the normal limits of error. The x-ray, however, showed a "closed-in sella." Pituitary tablets were prescribed without benefit, and she was finally advised to undergo an operation, and sent to us for that purpose. So far as could be determined, she was an over-conscientious and overworked medical librarian greatly in need of a long-postponed vacation, who incidentally had been reading a popular book on the ductless glands.

In contrast to this, let us turn to the surgeon-specialist and his worst fault, in that he often fails to see the patient whole. At the moment of this writing, Patient Number Two enters the hospital—a poor fellow who for several years has been having frequent uncinate seizures, associated with a vivid olfactory impression. Meanwhile, he has had nine intranasal operations in separate sessions—a septal resection, ethmoids, sphenoid and both antra opened and drained, turbinates removed, and finally all his teeth ex-

tracted. Of course we smell with our noses; the patient complained bitterly of a disagreeable odor, *ergo* nasal operations. What could be more simple? That he had during all this time an homonymous hemianopsia was not observed. It is a venturesome and expensive thing to consult a surgical specialist who does not see beyond his own—or his patient's—nose. And this represents for all of us the great danger of surgical specialization, when carried to an extreme, whether it be in rhinology, gynaecology, neurology, or what you will. And when the specialty removes itself from contact with general Medicine, and retires to an isolated hospital given over to a single class of cases, it is a danger scarcely to be avoided. Indeed, a ward in a general hospital, so given over, may become no less a place of isolation with its inevitable narrowing tendencies.

A wise physician and teacher, in discussing internal medicine as a vocation, once said that "the manifestations of almost any one of the important diseases in the course of a few years will box the compass of the specialties." It is no less—perhaps even more—true of surgery, and for this reason I believe it to be fundamentally essential in a general hospital, however inconvenient for the attendants, that conditions represented by the specialists shall be scattered in the wards amongst the patients still grouped under general surgery, so that staff, house officers, nurses and students alike shall at least continue to have some due sense of proportion regarding general surgery, and surgical specialization, and the relation of both of them to Medicine.*

THE RÔLE OF THE COLLEGE.

This College of Surgeons in its short life has assumed some very responsible functions. It is playing a not unimportant rôle in international affairs by bringing together through the common bonds of professional interest the surgeons of this western hemisphere—of Canada, Mexico and South America, as well as of the United States. We have much to learn from each other. Another most important task it has undertaken is to improve, and in a measure to standardize, the work done in our larger hospitals. The modern "Survey" with public ventilation of its findings is one of our most advantageous methods of bringing about reforms. So our hospitals, some seven hundred in number, which have over one hundred beds, have been classified, with the result that improved methods of organization have been adopted which have enormously safeguarded the patient—particularly the patient destined to undergo the hazards and aftermath of an operation. It has been an expensive and laborious task, this survey, but a task well worth while, and it is now to be extended so as to

include the smaller community hospitals of over fifty-bed capacity, which are far and away more numerous.*

The College, too, has from the outset taken a vigorous stand against that abomination which prevails, it is said, in some parts of the country to such an extent that public confidence in the profession has been seriously shaken. It is a matter which bears some relation to these very trends of physic and surgery which I have endeavored to make clear earlier in this address—the surgeon becoming a pure operative technician, incapable of making a diagnosis—the physician, impoverished in therapeutic resources, and with so poor a conception of surgery that he will let out his patient to the lowest bidder willing to operate at his dictation, and divide the purse! This takes us back to the abuse of the Middle Ages. It is an abuse which could not possibly exist in any community if the surgeon was trained to make his own diagnosis, and if the physician would refuse to employ a surgeon incapable of arriving at an independent opinion regarding the necessity or advisability of an operation. For such a man is apt to be equally neglectful of what is often the most important part of every surgical procedure—the after-treatment. The physician who lends himself to such a practice is in the position of one who prescribes a dangerous drug to his patient without knowledge of its dosage or action, for there is no drug in the pharmacopoeia so dangerous as misapplied surgery.

It seems to me that it would not be a bad idea if in our tests of eligibility for fellowship in this College—tests which not only are those of moral and professional character but of operative experience and skill—we should require something more than the mere report upon a fixed number of major operations successfully performed, but should require, as well, information as to whether the diagnosis of these cases were the result of the candidate's own personal observation, or whether they were made for him by another.

We have seen that the present trends affecting the physician and surgeon are, on the one hand, toward preventive medicine and good nursing, which lessens the importance of therapeutics; on the other, in surgery, an ever-increasing subdivision and specialization which tends to magnify the importance of mere handiwork. Prevention, it is true, can also be applied in surgery. Many industrial accidents can be prevented; the rule of safety first can be followed; there would be no more gunshot wounds if fire-arms and war were abolished; if we can finally stamp out tuberculosis and eliminate cancer, there will be far less for the surgeon to do. If women did not have children, if people did not drink, if we

* I do not know that a proposal that my medical colleague and I exchange places for a few weeks each year will ever be acted upon, but we at least hold a conjoint visit of the medical and surgical staffs once a week, and thereby endeavor to see Medicine whole, and to encourage our students to do so.

* It may be noted that 75 per cent. of the one hundred-bed hospitals had adopted by 1921 at least the minimum standards of acceptability, whereas in 1918 only 18 per cent. of the 692 hospitals surveyed had been accepted.

* It is significant of the success of some of the activities the College has engaged in, that laws against fee-splitting have been adopted by many State legislatures.

could only keep the policeman off his feet, the housemaid off her knees, the miner off his elbows, the aviator out of the air, the boys away from football; if all children in goitrous districts were given a little iodine, there would be less need for the surgeon. But we do not yet live in the Isle of Utopia, and however much the need of the physician may be lessened through the agency of preventive medicine, by eliminating disease as typhoid has been largely eliminated, and yellow fever, and as malaria can and will be, and many nutritional disorders, and perhaps goitre, the surgeon will continue to be needed, and I cannot see but that he must become a better and better physician.

When physicians acquire a more intimate knowledge of surgery, fewer people in need of operative procedures will be turned over to the surgeon too late, after delays caused by an inordinate number of unnecessary laboratory procedures. When surgeons are required to have a thorough grounding in general Medicine before practising their handiwork, fewer unnecessary operations will be done, and many of the evils which exist in their professional relationship with physicians will be eliminated.

All of which was said as well and more briefly by Lanfranc: "No one can be a good physician who has no idea of surgical operations, and a surgeon is nothing if ignorant of medicine. In a word, one must be familiar with both departments of Medicine."

New England Hospital Association.

ANNUAL MEETING WEDNESDAY, MAY
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LIBRARY.

(Continued from page 607.)

"PRINCIPLES TO FOLLOW IN BUILDING CHILDREN'S WARDS AND WARDS FOR CONTAGIOUS DISEASES."

BY DR. D. L. RICHARDSON, PROVIDENCE CITY HOSPITAL, PROVIDENCE, R. I.

It is very appropriate that the construction of wards for children and contagious diseases be discussed together. In 1913 in a paper read before the A. M. A. at Atlantic City, the author pointed out that the same principles in the construction and management of contagious hospitals apply equally well to children's hospitals, and subsequent experience had confirmed that belief.

I need not emphasize to you how frequently infectious diseases break out in children's hospitals. I am not aware of any published statistics upon the subject, but many superintendents have stated that some of their wards have been under quarantine at least half of the time. This may be a high estimate, but even if wards are

closed because of contagious disease during only a third of the time, it results in great economic loss and usefulness of the hospital—to say nothing of the notoriety such outbreaks sometimes occasion.

The manner in which ward space is divided bears an important relation to the spread of infectious diseases, once introduced. But it is not the only consideration, not even the most important. Too much attention has been paid to construction and too little to the careful examination of every new patient, to careful supervision once the patient is admitted, and the utilization of strict cleanliness, medical asepsis, by nurses and doctors. The purpose which divisions of the ward serve, is to keep patients apart, for the danger of atmospheric infection has been conclusively shown to be of very little importance. It is assumed, therefore, that it is not necessary to discuss aerial infection as bearing upon the construction of children's hospitals of whatever kind. That it may take place at very short range, as when beds are very close together or a patient coughs in the doctor's or nurse's face, is possible. Even under such conditions contact still is the most important factor in transmission. Whatever the means employed for separating patients from physical contact, they operate also to interrupt possibilities of air infection. This statement is for the benefit of those who still cling to this favorite misconception.

To fully appreciate the proper type of construction it is necessary to briefly consider how infection enters a hospital and how it spreads after once admitted.

Ask almost any hospital superintendent how contagious diseases are introduced into hospital wards and he will invariably say, by visitors. While it will not be denied that this factor is entirely a reasonable assumption, particularly when children are allowed as visitors, it operates in a very small percentage of instances as the cause of hospital outbreaks. The real factors are the patients themselves. It cannot be too strongly emphasized that exact diagnosis of infectious diseases is impossible. There is such a large number of cases which cannot be recognized clinically. Of all patients admitted to a hospital, medical cases suffering from acute disease are the greatest menace. A child is admitted with a diagnosis of broncho-pneumonia, which is no diagnosis at all, may be suffering from measles even in the absence of a rash. Another child may be admitted for tonsillitis and really be suffering from either scarlet fever or diphtheria. Oftentimes children with a cough, treated as a bronchitis, are suffering from whooping cough. Rashes are overlooked or wrongly interpreted.

These things are pointed out to show the difficulties of the situation. In addition to mistakes in diagnosis, children may be admitted during the incubation period of some infectious disease, which not infrequently gives rise to an out-

break. And lastly, of all hospital admissions a certain percentage of patients are infectious disease carriers. For practical purposes every outbreak arises from one of these three sources,—unrecognized cases, patients in the incubation period, or acting as carriers. While visitors and packages may, theoretically, be a possible avenue of infection they can be ignored, and the investigation of the source of any outbreak should be devoted to a careful examination and supervision of all patients in the ward where the outbreak occurs.

The first important hospital rule should be, that every new patient be seen promptly by a competent diagnostician and the examination not left to an interne. In small hospitals it may not be possible to get a physician to see every patient on admission, but the patient should be treated in a separate room until the admitting physician has seen him. Every children's hospital should delegate to some resident or visiting physician the responsibility of admitting all new patients, of designating the ward or room where they shall be treated, and be called at once to see every patient who develops a rash, unexplained temperature, sore throat or other suspicious sign, as an important method of minimizing the danger of outbreaks of contagious disease.

Realizing that even the best diagnostician is liable to error, it is essential to so construct and conduct the wards that even if infection is introduced it will be limited to the least possible extent.

The spread of infectious diseases within the hospital is accomplished by actual contact between patients and indirect contact by nurses' and doctors' hands, nursing utensils, dishes, etc.

To separate the patients from physical contact three means may be employed: Putting the beds some distance apart, the interposition of a partial partition between patients, the cubicle system, and the construction of separate rooms each to contain few patients. In older hospitals which are provided with large open wards, beds may be spaced at a distance of five or six feet, or better by the construction of cubicles. Space may be conserved by the latter method, for the beds may be placed much nearer together, and yet the danger of the children coming into actual contact is slight because of the partial partition. In the construction of new hospitals, separate rooms should be constructed with enough glass in the walls to provide for easy observation and contentment of the patients by permitting them to see other patients in adjoining rooms. The installation of a large amount of glass in corridor or inter-room walls is a mistake because it is so expensive to clean and makes privacy impossible. Particularly in contagious wards one never knows what diseases to expect nor what ages will be affected, and construction should be so planned that all wards may be used for any disease or for either children or adults. Physi-

cal separation of the patients is accomplished by one of these three methods. If it is desired to keep from actual contact, direct or indirect, patients in the same room, some kind of a card should be hung on the bed to indicate this to the nurse.

Children can thus be grouped singly, or in larger groups, those who are suffering from the same disease being confined to one group, or for the purpose of dividing them in small units between which there is no contact, direct or indirect. The importance of dividing wards for children or contagious diseases into rooms to contain one, two, or three, or at most six patients, cannot be over-emphasized. The partitions separate the patients into small groups and they can be easily confined to their own rooms, which is almost impossible in a large ward even if the beds are well spaced. After the lights are out at night or even in the day it is impossible to keep them from getting out of bed and sometimes coming into contact with each other.

However, if every patient had a single room throughout hospital residence, infection might be carried from one room to another by indirect contact by nurses, doctors, utensils, etc. It is absolutely necessary to practice strict cleanliness between different groups of patients, particularly when they are in the acute process of the disease. Once infection is introduced into a ward or room containing twenty or thirty or more patients it spreads to nearly all susceptible children. If, however, the units or rooms are small, infection will be confined to those in the same room or unit and will not spread to other rooms if strict cleanliness be employed.

The ward construction to be described applies equally well to wards for general diseases of children or for one kind of infectious disease. It is of great advantage to construct all wards along similar lines so that the hospital capacity will be elastic.

Each ward or floor should be composed of small rooms for new patients, larger rooms for convalescents and the necessary utility rooms located between the two. The rooms for new patients should be designed to contain one or two beds, rarely three, and should contain about 50 per cent. of the ward capacity. All new patients should remain in detention for one week, during which time a more accurate diagnosis can be made to determine whether the patient is suffering from a contagious disease when in a general hospital, or from other infectious disease than the one treated in that ward if in a contagious hospital. The convalescent rooms, which should accommodate one-half the patients, should not contain over five or six beds each. A child might be under observation for a week in a detention room yet after transfer to a convalescent room develop measles or chicken-pox or some other disease with a long incubation period. If there are at most five other patients in the convalescent room part of them are like-

ly to be immune and the outbreak will be confined to one or two patients. This presupposes that patients in different convalescent rooms on the same floor are not allowed to mingle, that nurses' and doctors' hands be washed between rooms, and all utensils sterilized each time used.

The division of the ward floor into small rooms will be almost useless unless every room is provided with a lavatory where the nurse or doctor, after handling patients in the room, can scrub their hands in running water which can be turned on by foot or forearm valves. It is also essential that the kitchen be provided with a utensil sterilizer where all dishes can be boiled before washing, and the utility room with another sterilizer in which bed pans and urinals can be boiled after emptying. There should also be a clothes chute into which all linen, infected or otherwise, can be dropped piece by piece as occasion arises. The underlying idea is to consider all rooms occupied by patients infected or potentially infected, while the ward corridor and utility rooms remain uninfected. In the control of infection in a contagious hospital this principle is essential to maintain, and, what is more, it simplifies and makes consistent the whole technique.

The materials used for wall and floor construction are quite unimportant, for infection from them is very remote. It is advisable to use such materials as can be easily cleaned with soap and water. I am sure that excellent results can be obtained in even the temporary wood-constructed hospital if the rooms are small and provided there are lavatories, if there are sterilizers for utensils and the ward managed by a trained personnel.

Isolation wards where a variety of diseases can be treated should preferably be made up of rooms or cubicles, each containing one bed. For some purposes two or even three beds are allowable in the same room.

In every children's hospital of any size there should be an isolation ward composed of single rooms, to which all suspicious cases can be sent for observation, and where even infectious diseases can be treated if they cannot be sent elsewhere. The technique should be rigidly enforced. When you once have such a ward you will realize how indispensable it is.

By adopting this type of construction and strict cleanliness in the nursing care of patients, when a child develops measles, for instance, it is not necessary to close the whole ward. It is only necessary to isolate for observation those patients in the same room who have never had measles. In over twelve years no ward has ever been closed at the Providence City Hospital because of the occurrence of an outbreak of some infectious disease. Patients have been admitted to other rooms in the ward just as if nothing had occurred.

The nursing care as carried out in a contagious hospital is very rigid, but it can be modified for general hospitals for children.

It is not to be expected that cross-infections can be eliminated altogether from children's hospitals, but they can be lessened and the hospitals be conducted so that a whole ward need not be quarantined when a contagious disease appears in one of the rooms. The work can go on as usual after the case is disposed of and the "contacts" put under observation.

The cross-infection rate at the Providence City Hospital, a hospital for contagious diseases only, has been as follows:

1910	2%
1911	2%
1912	6.3%
1913	1.7%
1914	1%
1915	4.6%
1916	1.8%
1917	0.8%
1918	1.9%
1919	0.5%
1920	1.4%
1921	1.9%

During this period the diseases treated are as follows:

Chaneroids	21
Chicken-pox	163
Diphtheria	3,560
Diphtheria with other infectious diseases	131
Diphtheria carrier	254
Erysipelas	112
Gonorrhea, female	45
Gonorrhea, male	125
Gonorrhea, ophthalmial	19
Gonorrhea, other forms	29
Gonorrhea, vaginal	66
Impetigo	29
Influenza	459
Influenza with other infectious diseases	12
Influenza with pneumonia	88
Laryngitis, negative cultures	63
Measles	1,106
Measles with laryngeal diphtheria	41
Measles with other infectious diseases	98
Meningitis, cerebrospinal epidemic	48
Mumps	81
Mumps with other infectious diseases	4
No diagnosis	84
No disease	208
Noma	5
Other diseases	994
Pneumonia, all forms	58
Poliomyelitis, acute	64
Poliomyelitis with other infectious diseases	3
Rubella	148
Rubella with other infectious diseases	6
Scabies	35
Scarlet fever	2,752
Scarlet fever with diphtheria	57

Scarlet fever with other infectious diseases	135
Septic sore throat	14
Syphilis, active and latent	43
Syphilis, cerebrospinal	128
Syphilis, congenital	41
Syphilis, organic	10
Syphilis, other forms	1,855
Tonsillitis	539
Trachoma	12
Tuberculosis, pulmonary	1,906
Tuberculosis, meningitis	28
Tuberculosis, other forms	40
Typhoid fever	9
Typhus fever	4
Variola	31
Vincent's infection	28
Whooping-cough	391
Whooping-cough with other infectious diseases	17
Total	16,199

I venture to suggest, in the absence of exact statistics, that these rates, indicating the per cent. of patients contracting a second disease, compare favorably with the cross-infection rates of any hospital or wards used for children suffering from general diseases.

DR. HOWLAND: Dr. Richardson's paper is open for discussion.

MR. STEVENS: I should like to ask Dr. Richardson one or two things. In his three or four-bed convalescent ward, and in his two-bed admitting ward, would he advocate a screen, either permanent or temporary, between the beds, or would he space the beds some distance apart? Would he in the cubicle, or rather the admitting single rooms, advocate the placing of water-closets in the room, or adjoining the room?

DR. RICHARDSON: Relative to the screen, I don't think it matters so much, when you have only two or three beds in a room, if you use those small rooms for admitting new patients. The danger of contact, if the beds are well spaced, say four or five feet apart, is slight, because the patients are too ill to come in contact with each other. The question of convalescence is another question. The question of having water-closets in the room or in a room adjoining the isolation room is purely a matter of expense. In a hospital for contagious diseases, 80% of the patients are under ten years of age, and by using the bed-pans now generally used in hospitals, which can be used on the bed or on the chair, we don't find any great difficulty in having the patients use them, supplying on that floor a certain number of water-closets, toilets, to which adults can go. But when you begin to put a toilet into every room, or even between every two rooms, you are adding not only to original expense, but to the expense of upkeep, and while it is perfectly all right, and a very good idea, it is just a matter of how much money you can spend.

DR. WASHBURN: Do I understand that Dr. Richardson would be willing to put toilets in patients' rooms under any circumstances?

DR. RICHARDSON: I didn't have in mind that particular question. I suppose it would be perfectly possible. I am told that in European hospitals they have them in the open ward; I think that perhaps this country might not submit to that.

DR. HOWLAND: I think Mr. Stevens had in mind a closet between rooms, so that there would be no direct contact with the room except by a door or curtain. Have you seen such installation in contagious hospitals? A. Yes, a toilet for each individual room.

DR. HERSEY: I should like to ask, if where there is a cubicle installed in the ward, and those wards are used for contagious cases, whether it is necessary to arrange further for a curtain across the end of the cubicles in case contagious cases should develop in the cubicles?

DR. RICHARDSON: The chief difficulty we have with cross-infection is with chicken-pox and measles. These are the only two diseases that we exclude from any of our open wards. It is necessary to exclude measles from the beginning of symptoms until about 48 hours after the beginning of the rash. There is very little danger after three or four days from the beginning of the eruption of chicken-pox. We interpret this rule about admitting infectious diseases rather liberally. We have tuberculosis, syphilis, cerebrospinal meningitis, and a great variety. In other words, we admit any kind of infectious disease. We use the open ward for babies with any disease except chicken-pox and measles.

DR. HERSEY: One more question: how about acute infections, the ordinary cold; in cases of that sort, with the possibility of the infection going through the hospital, would you be any more likely to prevent it by using curtains?

DR. RICHARDSON: I am very much opposed to curtains. Partitions are all right to help control children. There is no danger as far as infection through the air is concerned, unless the beds are very close. If you hang up those things, you rely on them, and won't wash your hands. The important things are to sterilize your instruments; keep the patients apart; insist on nurses and doctors washing their hands every time they pass from one group to another; sterilize dishes and utensils.

DR. BROWN: How do you explain the wide variation of cross-infection in 1912 and other years?

DR. RICHARDSON: That was a year when we were jammed full of measles, and we had more cases than we could take care of. A hospital for contagious diseases can take so many patients

and take care of them properly; when you overcrowd the hospital, you do more damage than good. A hospital superintendent should refuse to take more patients than can be well cared for; it only spreads the epidemic. In an epidemic, all he can do is to take the sickest cases, and only such number as he can take care of comfortably.

DR. HOWLAND: Tomorrow afternoon, when we visit the hospitals, if anyone is interested in the subject of isolation wards, the Boston City Hospital has just built two, one in the South Department and one in the general wards particularly for the reception of children. You will see many interesting and ingenious things there, especially the means for sterilizing, ward apparatus, steam closets, and fumigating closets for sterilizing. It seemed to me very practical and very simple.

If there is no further discussion of Dr. Richardson's paper, we will proceed with the question-box.

QUESTION-BOX.

X-RAY DEPARTMENTS.

Question: What is the most equitable way of managing an x-ray department in a small hospital where it is impossible to employ a physician for that service as full-time paid officer? What is the salary of a roentgenologist? Does he have a technician? and what are the arrangements? What is the best way to compensate doctors for reading x-ray plates?

DR. PETERS: At the Rhode Island Hospital, we have had, until within a few months, a man who gave his full time, on salary, to the work of the hospital. Recently that man has been given permission to devote his afternoon hours to his private work. He gives the hospital four or five hours in the morning to the interpretation of plates as taken by the technician. So far as I know, it has been satisfactory. This man has given his readings promptly, and his presence hasn't been missed in the afternoon, because of the arrangement and the system of having his plates there, and a dictaphone into which he could talk if the stenographer was not there. I think the work has been done satisfactorily. I have no opinion in regard to the work in small hospitals, based on experience, but I do know some small places where they employ men to go at intervals to do all the work, or to interpret the plates taken by a trained technician.

DR. DREW: Our roentgenologist is not on a salary. He receives 80% of the fees from paying patients, but he does not receive any compensation for reading plates for non-paying patients. This man feels at times that he isn't paid enough, because we insist on making only one charge for an x-ray plate of one part: that is, if we take a series of stomach plates, and they don't come out right, and the x-ray man wants to repeat them, we make only one charge, because we feel

that we ought to stand our own failures. I have had a pretty strong feeling that the x-ray man ought to be on a salary, and that there ought not to be any division of fees between the hospital and any expert connected with the hospital.

MISS BARNABY, Henry Heyward Hospital: For the past two years, we have had a Harvard Medical student who gave his time entirely to x-ray work. In the winter he came Saturdays and Sundays. One of our nurses was trained under him and under Dr. Jennings of Fitchburg, consulting roentgenologist. Then Dr. Jennings came to the hospital once or twice a week and read the plates, which are then typewritten and sent out to the doctors who send in the patients. Now the student has graduated, and we are having a regularly trained technician come in permanently, while the former student is going to give us one day a week. He has settled in Boston.

Q. Do you pay the consultant?

MRS. BARNABY: He has been paid on a 50% basis.

DR. BROWN, Burlington, Vermont: Our x-ray department is highly developed for a small hospital. We pay our x-ray man 75% of all money collected for x-ray plates, and he pays his own technician. He does our laboratory work, blood work, and urine tests. The free x-ray work he does for nothing. The department has grown so, and has come to be so necessary a part of the hospital, that I think his income last year was over \$10,000; that is, for his share of the receipts. The department has grown very rapidly. It is a very necessary part of a modern hospital, and some of it, I think, might be developed in almost every hospital. Out of that money, we have paid for all of our apparatus in recent years, with some little money to the good. The department is practically self-supporting. That doesn't include overhead expenses, or bookkeeping, but it includes the cost of supplies, apparatus, and what services are required. The x-ray man, as I have already said, pays his own technician. So, on the whole, on that basis, it has been a very good thing for us, as well as a good thing for the public and for the x-ray man, who has found it worth while to devote his entire time to it. That includes all routine laboratory work.

WOMAN: Our x-ray department has been self-supporting. We have a man who does our x-ray work, and he has 40% of all charges collected by the hospital, and 25% for each extra plate. He does the fluoroscope work. The doctor who interprets the plates makes no charge.

LABORATORY CHARGES.

Question: Should pay patients be charged for blood counts and for examination of urine?

Should there be a flat laboratory charge for all patients who pay? What should the laboratory charge be, and for what?

Dr. STETSON: We have recently taken this matter up. It was first taken up by the staff, and the staff held that there was no reason why a laboratory fee should not be charged, the same as a fee for the operating-room and a maternity fee, and, after considerable discussion, it was finally recommended to the trustees that a flat rate of \$5.00 be charged all patients who have any laboratory work done, with this exception, that an initial complete urinary examination and an initial white count on admission, for purposes of diagnosis, should not be charged for; that that should be done as a matter of routine. For any examination of urine, blood, stomach contents, and other laboratory work, including all laboratory service, a \$5.00 fee was recommended, and the trustees have accepted that recommendation.

Q. Does that apply to ward patients?

Dr. STETSON: To everybody. The laboratory worker doesn't know who is on a free bed. If it is a free bed patient, it is charged off.

Dr. HOWLAND: I think it is desirable, if there is to be a laboratory charge, that it should not be strung out into various items. Patients are irritated by a bill with many items in it. It is much more satisfactory, if you are going to have a laboratory charge, to make it an inclusive one, regardless of what you do, much or little.

Dr. STETSON: All the staff, with one exception, were entirely agreed as to the charge. The feeling was that if a fee was charged for each separate service, patients might many times be deprived of necessary or desirable laboratory examinations, because the physician would feel that he did not want to run up the expense, and that better results would be obtained, and the physicians would be encouraged to use the laboratory, if a flat rate were made; and it has worked out in just that way.

Dr. PETERS: Mr. Chairman, it would be interesting if those here who do make charges for laboratory work would indicate it by rising.

Response showed: Open ward patients charged, 10 hospitals; private ward patients charged, 21 hospitals; no charge for laboratory work, 20 hospitals.

ACCIDENT CASES.

Question: What can be done to collect from insurance companies on accident cases? Insurance companies sometimes pay the family, and the hospital doesn't get anything.

Dr. HOWLAND: I assume that that question comes from outside Massachusetts, because here we have the Workmen's Compensation Act.

Dr. SMITH: We have an industrial accident law that protects the physician and the hospital. Our Industrial Accident Commission sees that the hospital is paid and that the individual doctor is paid, even if the patient is in the hospital. We have no business relations with the insurance company.

(Woman from Waltham Hospital explains that the question refers to automobile accident cases).

Mr. BORDEN: In automobile cases, where the insurance company pays the damages, the hospitals have no claim whatever against the insurance company. The insurance company assumes liability and pays damage to the person who is injured. The amount is supposed to be sufficient to include the cost of medical and hospital treatment. Fundamentally, the person to whom the hospital should look for payment is the person to whom damages are paid as the result of the accident.

WOMAN: I have been in a hospital where there were a great many automobile accident cases—six, eight, or ten such cases in the hospital at one time. We asked if there was insurance. We found the companies were very willing to see that the hospital was compensated. We never had any difficulty if the patient was insured. We never lost any money on an insurance accident case.

WOMAN: We sometimes have just such accident cases, when we are urged by the insurance company to do everything possible to save the patient's life. Then later they sometimes say that they are not liable, and the hospital has difficulty in collecting from the patient. In one special case, there was a small child who was insured. The family questioned the amount of the expense, and in that case, of course, the expense was going on before it was decided who should pay it.

Dr. HOWLAND: I think Mr. Borden, who is a lawyer, very clearly covered this question, speaking from a legal point of view. We have no claim on the insurance company. The insurance company is responsible to the injured person. If there is anything to be collected by the hospital, it is from the patient. The insurance company will work with us sometimes, but we have no claim on them.

REFRIGERATING PLANTS.

Question: Who has a refrigerating plant he will recommend for a hospital of 125 beds? What is the cost of installation? and what is the expense of upkeep? Is it difficult to run? or can it be taken care of by the engineer, in addition to his other duties?

Dr. HOWLAND: Miss Barnaby, you have a hospital of about 125 beds; do you have a refrigerating plant?

MISS BARNABY: Our hospital has really only 100 beds. I don't know whether our plant is large enough for a hospital of that size or not. I can't tell the cost of the installation, because it was included in the new building. Our engineer with his assistant does take care of it. We have had it running about two months. It is called the Johns-Manville machine. It is supposed to be a self-contained machine, with nothing to do but keep the motor running.

Another speaker (man) says the apparatus costs about \$7,000.

DR. RICHARDSON: We have just installed one at the City Hospital. It is too early to know whether it is going to be satisfactory or not. Most all of the wholesale beef houses and all the business men who are using refrigerating plants swear by this concern. For space we have one room about 12 by 13 feet; we have four other compartments, which all together contain about 12 by 20 feet, divided up into sections; and then we have a freezing compartment that will freeze about 1500 pounds of ice a day, and a morgue box which will accommodate three bodies. The cost of installation was \$9,000. The cost of upkeep is not yet known, probably not over \$40 or \$50 a month. Our engineer looks after it.

MR. STEVENS: I have put in a number of refrigerating plants,—200 put in by the Erie Company. One thing I try to avoid in putting in refrigerating systems in a hospital is the use of ammonia, by using other things. I have had very good success with sulpho-dioxide in refrigerating systems in self-contained systems. I use ammonia where the plant is large enough to be entirely outside of the building.

DR. RICHARDSON: We considered that matter of using ammonia. A number of people said they had had no trouble, and other people said they had had trouble. The supply pipe of liquid ammonia has a pressure of 150 pounds; we run that out of doors. The return pipe has a pressure of something like 25 or 30 pounds; that would be a slight leak, if any. The other is out of doors, so the danger is not great.

DR. FAXON: At the Phillips House, we have a Johns-Manville installation. It has been very satisfactory. It needs very little care, apparently, from the engineer. It produces perfectly satisfactory refrigeration. We also have a machine of a similar type which was put in to take care of refrigerating the ice-box in the kitchen for the General Hospital, which has also been very satisfactory.

One word of caution that I would like to suggest is, in the installation of such things in a modern fire-proof building construction, put your ice machine outside of the general frame of your main building. If you put it in the basement of the building, it will cause a little vibration to be carried up through the steel beams for

several floors. That can be avoided if you know about it.

I don't know the cost of installation.

VACATIONS.

Question: How long a vacation does the superintendent allow staff nurses? social service workers? If a nurse is to leave at the end of the year, would the hospital be expected to pay her for a vacation?

MISS SELBY, Pawtucket: We give the staff nurses one month's vacation, and I should feel that if a nurse had put in a year's work, she was entitled to her month of pay, even if she were not coming back. Our social service worker has a month.

MR. BORDEN: I quite agree that a month is a fair time for either a nurse or a social service worker, because I think the work is very engrossing, and it is in the interests of the hospital to give them that vacation. But I don't understand why a nurse who is going to leave the hospital should be paid for that month's vacation. Most people don't get a month, and the only reason why a hospital gives that length of time is that the nurse should be thoroughly recuperated. I should hesitate to give that vacation, if a nurse told me she was going to leave.

DR. HOWLAND: I think sometimes a great deal of agony is saved if you make the vacation four weeks, instead of a month; it saves quite a lot of trouble and wearing out of the calendar.

SALARIES.

Question: What salary is paid a graduate nurse in charge of the operating-room?

MISS HALL, Peter Bent Brigham Hospital: We pay \$100 a month to the supervisor of the operating-room at the Peter Bent Brigham. We have been paying that for several years. A survey made of 1115 hospitals, two or three years ago, brought out the fact that representative hospitals were paying \$100 to \$125 for operating-room supervisors. That was in hospitals of from 200 to 300 or 350 beds.

DR. HOWLAND: What do some of the smaller hospitals pay the nurse in charge of the operating room?

MR. BORDEN: Our operating-room nurse, who has three rooms, gets \$125 a month and maintenance. The nurse who has charge of the operating department of two rooms gets \$90. We expect to raise it to \$100. Our hospital doubled its capacity last year.

MISS WEST, Beverly: We pay our operating-room nurse \$85. It will be increased.

MISS BOOKER, Corey Hill Hospital: We have two nurses in operating-room. The senior has \$85; the other \$80.

RAW FOOD AND PER CAPITA COSTS.

Question: For a basis of comparison, What are the per capita costs for raw food in various hospitals? What are the total per capita costs in various hospitals for care of patients?

MR. BORDEN: At the Fall River Union Hospital, the cost per capita for uncooked food per day was \$0.36, and \$3.73 a day per capita for care of patients.

DR. FAXON: The food cost at the Massachusetts General is \$0.44 a day, and care of patients \$5.08 per day,—that is, for the General Hospital.

MISS BARNABY: With a daily average of 40 patients, the uncooked food costs \$0.50 per day per capita, and the cost for the care of patients is \$5.75 per day. We employ graduate nurses only, with attendants.

MISS SELBY: Our per capita cost for uncooked food is \$0.595 a day; the daily average cost of the patients is \$4.95.

INTERNES.

Question: How many internes, if any, should a hospital of from 50 to 75 beds have? If more than one, should their work be divided? Regarding payment of internes, do any of the hospitals represented here give an allowance to internes? If so, how much?

MISS WEST: We have averaged 50 patients, and have had one interne. He took care of the ward patients. We paid him \$50 a month. This year we are to have two internes, neither of whom will receive any salary. Their working arrangement has not yet been decided. They serve for twelve months. This year we expect to have more patients.

DR. BROWN: The American College of Surgeons allows one interne for each twenty-five patients. We give our internes \$50 when they leave, to pay their car fare out of town.

DR. RICHARDSON: Our internes have \$25 a month for the first three months; the second three months we pay \$50. They come for six months' service.

MRS. SHEPARD, Mary Hitchcock Hospital: We have a hospital of 70 beds. When we can get them—we haven't been able to for the last two or three years—we have two graduates. They act as junior and senior, junior the first six months, and senior the last three months. We have a pretty active operating-room service, three or four a day; in the last six months they assist at the operations. We do not pay them.

Meeting adjourned at 4:30 p. m.

(Dr. Richardson's Tables.)

PROVIDENCE CITY HOSPITAL.

Cross-Infection Rate.

1910.....	2 %
1911.....	2 %
1912.....	63 %
1913.....	17 %
1914.....	1 %
1915.....	4.6%
1916.....	1.8%
1917.....	.8%
1918.....	1.9%
1919.....	.5%
1920.....	1.4%

DISEASES TREATED FROM 1910-1920.

Chicken-pox	140
Diphtheria	3481
Erysipelas	100
Gonorrhea	210
Influenza	557
Measles	1132
Meningitis	68
Mumps	66
Nurses, taken sick while attending patients	185
Other diseases	3270
Pneumonia	44
Poliomyelitis	87
Rubella	151
Scarlet fever	2744
Tonsillitis	482
Tuberculosis, children	31
Typhoid fever	9
Typhus fever	4
Variola	32
Whooping cough	383
Total	13,176

(To be continued.)

Original Articles.

A SPECIFIC SORE THROAT WHICH PASSED AS AN ORDINARY PHARYNGITIS AND TONSILLITIS, TREATMENT ADMINISTERED FOR SAME, WITH NO RELIEF.

BY DAVID B. MEDALIA, M.D., BOSTON.

It is my desire to publish this interesting case, to bring out the importance of a Wassermann in obstinate sore throats which do not clear up under ordinary treatments, especially persisting for a long time.

This patient, a man of forty-five, applied for examination and treatment of a very sore throat. He could not swallow except with great difficulty, whether warm or cold fluids; it pained him even to talk. History: Denies

specific disease, has been suffering from a throat condition for last few months. He was in Newport, Rhode Island, previous to his moving to Boston, where he went to a local physician, who examined him, told him he had a very bad throat, and gave him a gargle and a tonic, and told him to come back later for a urine examination. The patient did as he was instructed, for a couple of weeks. His condition became worse instead of better. He then left for Boston, and saw me the latter part of last April.

Physical examination was negative except for a few boils on his forearms, pyorrhea alveolaris and an ulcerated throat. There appeared to be a mucopurulent-like membrane covering the back wall of the pharynx, downward and upward, including the soft palate, extending to and overlapping both tonsils. The uvula seemed to be severed in two, the result of the existing ulceration. It looked to me to be one of four conditions, namely, diphtheritic, specific, tubercular, or malignant.

I made smears and cultures to rule out diphtheria, in which I succeeded; those showed no K. L., predominating micrococcus catarrhalis, streptococci and staphylococci.

At the same time I took a blood for a Wassermann, which was reported positive.

To the physician it had looked like a tertiary gumma, ruling out tubercular because of its wide distribution with hardly any destruction; and excluding the question of malignancy because of the fact that the patient could freely open his mouth widely with the least bit of pain or disturbance. Dr. Morton Smith advised the administration of antispasmodic treatment at once.

I started the patient off with Gr. V of K. L., gradually increasing it to Gr. XV t. i. d. and mercury inunctions. The improvement of the throat was miraculous, even before the administration of arsphenamine.

A week later I started him off with 0.2 mg. of arsphenamine intravenously, increasing the dose to 0.4 mg., which he is receiving every week, at the same time keeping up with the mixed treatment. Later I intend to give him 0.6 mg. of arsphenamine for a few weeks to complete the twelve injections before another blood test.

After an administration of four doses of arsphenamine his throat has cleared up entirely, and he has hardly any discomfort or pain left.

CONCLUSIONS:

One must always guard against specific sore throats, though the patient gives a negative syphilitic history.

It is important to take a blood test in cases of persisting sore throats accompanied by ulcerations, and which do not clear up under ordinary treatments.

587 Beacon Street.

A CASE OF INTUSSUSCEPTION.

BY PHILIP J. FINNEGAN, M.D., SALEM, MASS.

THE report of this case of intussusception may be of interest on account of the age of the patient and on account of the location of the condition. This girl, 6 years and 7 months of age, was taken sick with a "belly-ache" and cried on Friday morning, the 20th of January, but was sent to school. She seemed to be all right from then until the following night, when she had severe cramps with vomiting, which apparently was faecal, for her mother said it was "stinking." She continued to have these severe cramps and the vomiting until she came to the Victoria Hospital on the evening of the 24th. At that time, she had a temperature of 95.6, pulse of 130, and respirations of 25. From Friday morning she had no bowel movement and passed no blood or mucus; an enema, given shortly after entrance, brought some bloody mucus. Patient was thin and poorly nourished; skin and mucous membranes showed marked pallor; eyes had an anxious expression; tongue was dry and slightly furred with a brownish coat; patient was very restless and in great pain. She was vomiting constantly brownish liquid with a faecal odor, as she had been for three days. Examination of the abdomen showed a long tender mass in the middle of the right side of the abdomen beyond the rectus muscle. This mass appeared to be 8-10 inches long and 3-4 inches wide. Blood pressure: sys., 86; dias., 58.

Operation.—On opening the abdomen by a median incision, there escaped much thin blood-tinged fluid. On the right, a large mass was felt and found to be small intestine greatly adherent and massed together; much fibrin was scattered over the bowels and some bloody fluid was present in the pockets formed by the adherent gut. The caecum was freely movable with a small appendix and was not involved in the condition; the mass was at least eight inches from the ileocaecal valve and extended along the ileum for about twelve inches. The distal end of the mass was thick and indurated. The intussusceptum could not be reduced by manipulation and the gut was opened longitudinally and 10-12 inches of bowel the color of chocolate jelly was delivered and resected. A small necrotic sessile tumor, two inches long with a pedicle $\frac{1}{4}$ inch in diameter, and the blunt distal end one inch in diameter, was found in this necrotic gut at the apex of the intussusceptum. A lateral anastomosis was done and one drain placed in the pelvis and another higher up, but avoiding the anastomosis sutures. During the operation, the skin remained warm and her color and respirations were good, with the pulse running between 160 and 170. No stimulants were given; the patient was then put in Fowler's position with Murphy drip.

Following an enema on the next morning, some flatus was passed, and 36 hours after operation some fluid faeces were passed. From the third day on there were always 4 or 5 involuntary fluid movements, and on the sixth day after operation, there was a formed stool. During this time and for nearly three weeks there was marked distention, which was but little relieved by enemata. There was little if any discharge from the drainage wounds after the removal of the wicks on the fifth day: drains were not replaced. The distention caused the skin edges to gape, but they were pulled together by adhesive plaster. The distention gradually went down, the wound healed, and the girl went home in 5 weeks. For three weeks she had been on house diet and was comfortable except for the distention.

On June the first she is doing well and going to school every day: she eats well, sleeps well, and has had no abdominal discomfort since leaving the hospital.

A TWO-HEADED CALF.

BY EDWARD B. BENEDICT, A.B., BOSTON.

Harvard Medical School.

A TWO-HEADED calf was recently born at the Bothfeld farm in Sherborn, Mass. This calf had a single trunk, and only four legs, but its two spines, though gradually converging, remained separate all the way down and ended in two distinct tails. The two necks converged and joined externally at about the mid-cervical region.

This calf was the fourth offspring of a large pure-bred Holstein cow and bull; the other three calves had been normal. Ordinarily, a calf is born with forelegs first, then head, and finally the rest of the body. In this case delivery was in the following order: right foreleg, right head, left foreleg, left head, then body and hind legs. The delivery was considered a difficult one, as it took three hours, but, curiously enough, it was the delivery of the normal hind quarters that caused the most trouble. The calf did not live, and probably never even breathed, though during delivery of the hind quarters she worked both her tongues around in the manner common to a calf as soon as its head is born.

Examination of the back of the animal showed three separate longitudinal ridges. The lateral ones were due to the spinous processes of the two vertebral columns, and as these processes flared laterally in the thoracic region, there was produced a central trough. This trough was bisected by the median ridge, high in the thoracic region, low in the lumbar area, but traceable to the fused sacra. To make this middle ridge, pairs of short ribs from opposite sides united in the mid-line and sent an undivided process dorsally, thus forming a suc-

cession of spurious arches and spinous processes.

The lateral fore limbs were normal, but the median pair was represented by a broad cartilaginous plate evidently derived from a fusion of two scapulae. This was packed in between the two spines. Deep within the muscles at the root of the neck, and thus at the upper end of the thoracic cavity, there was a spherical cyst, 25 mm. in diameter, thickly lined with white hair. The double scapula and the dermoid cyst were the only indications observed of the median pair of fore limbs.

Internal examination revealed a complete or partial doubling of the respiratory, cardiovascular, and gastrointestinal systems.

The Respiratory System: Two entirely separate systems existed in the single thoracic cavity. A trachea led from each neck down to a pair of lungs on each side. The medial lungs were distinctly smaller than the lateral, and none of the four appeared ever to have been filled with air. This was probably due to the very imperfect development of the diaphragm. In place of a strong tendinous center, it presented two weak membranous layers enclosing between them a very large diaphragmatic hernia.

The Cardiovascular System: There were two hearts of equal size; and cephalad there were two distinct sets of blood-vessels. The arteries appeared to be normal except that the left subclavian of the right animal was suppressed, and the right subclavian of the left animal was abnormally small, save for a branch distributed to the median thoracic region. There were no limbs for these median subclavian vessels to supply. The arches of the two aortae came together in a single descending trunk above the level of the diaphragm.

The Gastrointestinal System: The abdomen of the calf normally is largely filled with the four subdivisions of the stomach. In this instance it was overcrowded with them, for there were seven, owing to the complete doubling of all but the abomasum. That is, the cleavage into two individuals had extended through the rumen, reticulum and psalterium, making two of each, and ended in the fourth stomach, or abomasum, which was only partly subdivided. The oesophagus and first three stomachs on either side were apparently normal, except that the rumen, or paunch, of the right side was in the diaphragmatic hernia. The stomachs of the two sides ended in an abomasum, which was one large lobulated sac, divided superiorly by a median septum. But this septum terminated below, so that there was only a single pylorus. The duodenum and all the intestinal tubes were single and normal, ending in a distended rectum containing abundant hair-filled meconium. The anus was perforate. The urogenital system was unaffected by the cleavage. Since the duodenum was single, those organs which develop from it,

the pancreas and liver, would, naturally, be single; and such was the case. But the liver, with its single gall-bladder, assumed a bilateral disposition across the body, receiving two umbilical veins, and emptying into right and left venae cavae inferiores, passing to the respective hearts. Although there were two stomachs, I

found only one spleen, which was on the left side.

In making this dissection I was assisted by Dr. F. T. Lewis, who expects to publish a note on the embryological significance of the conditions here described.



Unusual Relation of Styloid Processes.

UNUSUAL RELATION OF STYLOID PROCESSES OF RADIUS AND ULNA.

BY G. T. TYLER, JR., F.A.C.S., GREENVILLE, S. C.

During the examination of a patient, I noted that the styloid process of the left radius was about the same level as that of the ulna. Although there was no other abnormality of the fore-arm, I immediately asked the patient when she had broken her arm. When she replied that she had never received an injury, I examined the other arm and noted the same condition. The accompanying x-ray, taken with the hands in pronation, shows the interesting variation. The tip of the left radius lies a little above the plane of that of the ulna. The styloid process of the right is in the same plane as that of the right ulna.

I can give no explanation for this variation; nor have I seen a report of a similar case.

NOTE.

An unsigned criticism of an advertisement in the JOURNAL has been received. We are always appreciative of constructive criticism, but the general policy of editorial offices is to ignore unsigned communications. A written opinion only carries weight when the author is known.



Usual Relation of Styloid Processes.

Book Reviews.

X-Ray Dosage. By WILLIAM D. WITHERBEE, M. D., Radiotherapist Presbyterian Hospital, New York, and JOHN REMER, M.D., Radiotherapist, New York Hospital, New York. 87 pp. Illustrations 5. The MacMillan Company, New York.

This small monograph is a collection of the previous published papers of the authors.

The first thirty-six pages, about one-half of the book, are devoted to a discussion of the so-called "indirect method" of measuring x-ray dosage and of the formula devised by the authors. No mention is made of the various other methods of measuring dosage. The formula recommended is based on the four fundamental factors—the voltage, milli-ampereage, time and distance. The size of the area exposed is not considered.

The technique described by the authors has proved satisfactory in the treatment of superficial lesions where unfiltered radiation was used. When using filtered radiation, it is doubtful if their thesis is correct and it has not been generally adopted.

The latter half of the book describes the method of applying and the dose to be given in infections of the throat, diseases of the skin, uterine fibroids, menorrhagia and Hodgkin's disease. There is also a chapter on the cause and treatment of radio-dermatitis.

The treatment of the various subjects is necessarily brief and somewhat incomplete in a book of this size.

Studies from the Rockefeller Institute for Medical Research. Reprints, Vol. xlii. 1922.

Cowdry makes a plea for conservatism in invention of new terms.

Clark illustrates a device for the measurement of intravenous temperatures.

Stadie illustrates an oxygen chamber for the treatment of pneumonia, and reports a case in which the anoxemia was notably relieved.

Clinical and Operative Gynaecology. By J. M. MUNRO KERR, Professor of Obstetrics and Gynaecology, Glasgow University (Muirhead Chair); Gynaecological Surgeon, Royal Infirmary, Glasgow; Honorary Fellow American Gynaecological Society, etc. London: Henry Frowde and Hodder & Stoughton, the Lancet Building, 1 and 2 Bedford Street, Strand, W. C. 2. 1922.

The author explains in his preface that it has seemed advisable to keep the clinical and operative sections separate. This is a rather

distinct departure from most books of this type, but, because of the excellent drawings furnished by the author and the small descriptive paragraphs accompanying each plate, it would seem that this method has a distinct advantage. One is able to refer to the latter part of the book and find practically all operations briefly described by text and by the excellent outline drawings.

The pathology presented in the book is simply a working pathology suited to the requirements of those interested in the clinical side of gynaecology.

In the operative section, two chapters are devoted to general surgical details and technique. This possibly is unnecessary, as it has been the custom to incorporate such details in practically all surgical books for many years.

There are 31 chapters, most of them short and concise. There are 132 illustrations independent of the outline drawings of operative technique, and a few excellent colored plates. There is one particularly valuable chapter on "Nervous Disorders in Relation to Abdominal and Pelvic Diseases," by Ivy MacKenzie. The volume also contains five pages of outline drawings illustrating various pathological conditions in the pelvis. Such drawings as these we have not yet seen in any of the American textbooks; they are very simple and yet extremely adequate in illustrating the pathological condition which it is wished to describe. For instance, the drawing of an appendix situated in the anterior fornix is a most excellent drawing of an extremely rare condition. Another chapter of note is that on "Disorders of Function."

The book forms a valuable handbook for the busy practitioner or the hospital interne, and might well be used by the medical student.

As a combination of clinical and operative gynaecology the book has decided merit.

Mental Diseases: A Public Health Problem. By JAMES V. MAY, M.D., Superintendent, Boston State Hospital; Chairman Committee on Statistics, American Psychiatric Association; formerly member New York State Hospital Commission, etc. With a Preface by Thomas W. Salmon, M.D., Professor of Psychiatry, Columbia University, New York. 536 pages. Boston: Richard G. Badger. 1922.

This volume is in one respect unique among works on mental diseases, presenting, as it does, as a distinguishing feature, the statistical aspect of the subject. Under this head the author has brought together an array of heretofore scattered facts and figures, which, although they are in the main familiar to the psychiatrist, should impress thinking people generally and be especially helpful in the education of a public at last awakening to an adequate realization

of mental disease both as a far-reaching malady and a social and economic burden.

The parent, physician, clergyman, educator and sociologist alike can find here an ample supply of statistical data to fortify their views on the subject of the mental health of the community and the pitfalls that threaten it. In this connection it perhaps would have been well if something more than indirect reference had been made to the question whether or not mental disease is increasing, a point on which there is very general interest and, in spite of enlightening research, much popular misinformation.

Among General Considerations are the mental hygiene movement, immigration and mental disease, and endocrinology and psychiatry—subjects which do not often find prominent places in books on psychiatry. The psychiatry of the war is also given a brief but satisfactory résumé.

The latter half of the work is devoted to descriptions of the individual psychoses. The author has admittedly confined himself to reflecting the views of others, throughout the book using actual quotations from recognized authorities. Nevertheless the compilation of these chapters is so thorough, embracing, as it does, the development of each disease form according to the conceptions of different observers, as to make them especially valuable for reference purposes.

A Text-Book on Gonorrhoea and Its Complications. By DR. GEORGES LUYs. Translated and Edited by ARTHUR FOERSTER. 3rd Revised Edition. William Wood & Co. 400 pages, 212 Illustrations and 5 Colored Plates. Price \$6.50.

This book is one of the most fascinating treatises on gonorrhoea which the reviewer has seen. Its outstanding feature is the thoroughness with which the author goes into the various aspects of this disease. The history and pathology of this infection are unusually good. Luy's is an advocate of urethroscopy, a procedure which he apparently employs a great deal more than do most urologists in this country. He gives numerous illustrations, both in black and white and in colors, of the conditions which he has found. One feels that he is a past master of all the more delicate and expert intraurethral manipulations; he has something to say, either pro or con, in regard to the more unusual methods of treatment, such as the application of heat, ionization, and electrolysis.

The question might be raised as to the wisdom of so much manipulation as Luy's advocates. He states that the incidence of epididymitis is 25 per cent., a figure which seems to us to be shockingly high. It may be that this high percentage is caused by too extensive intraurethral treatment.

Luy's style is interesting, and is made more so

by the numerous résumés of cases, recited, with many a Gallic touch, as a bit of intimate gossip. His translator seems to have preserved this characteristic of the book very well, and except for a few passages in which he has been careless about his English, has done an excellent piece of work.

It would be beneficial to many American urologists to read this book.

The Psychic Health of Jesus. By WALTER E. BUNDY, PH.D. Pp. 299. New York: The Macmillan Co. 1922.

This volume can be discussed from two aspects, the theological and the psychopathological and psychiatric, but only the latter will be touched upon here. According to the author, the latter fields are entered into only so far as the contentions against Jesus' psychic health have forced the problem, and then only in its relation to the New Testament sources.

The book discusses in detail, the various psychiatric and pathographic accounts of the personality of Jesus, as to whether or not he was an ecstatic, an epileptic, a paranoiac or a neurotic. Such a discussion may be of value, but when any great leader in the world's history of thought or action is submitted to a psychiatric analysis, there can nearly always be found personality traits which can be easily labelled with a scientific terminology. Such labelling, however, can neither adequately express the greatness of the man nor detract one iota from his contribution to human thought, for all great men have something within them which deviates from the normal, and it is probably this very deviation which renders them great and makes them impatient and intolerant of the religious, scientific, social or literary trends of the age in which they lived. All great men possess to a higher degree than their ordinary fellow men, a creative imagination which manifests itself in that symbolic thinking which illuminates the reality of things in genuine truth and inspiration, so that their contributions become the common heritage of mankind.

It would seem that this attitude is in agreement with Dr. Bundy's summing up of the situation, for he states that the pathographers of Jesus "have toyed wantonly and wilfully with the figure in history to which are attached the sincerest sentiments and the dearest affections of the occidental religious world, and without sufficient reason or justification."

The book contains a few errors of psychiatric terminology, such as the use of the word "hallucinations" instead of "delusions," while the translation of the French word "*delirer*" is rendered "delirium." According to the bibliography, the author has overlooked Berguer's contribution to the life and personality of Jesus from the psychoanalytic standpoint published in 1920.

Miscellany.**OFFICIAL BULLETIN OF THE AMERICAN COLLEGE OF SURGEONS.**

Boston, October 23.—Hospital service to the public in Massachusetts has shown a marked advance in the past year, according to the fourth annual report of the American College of Surgeons, released here today. This report is based on a survey which includes personal visits to each hospital of fifty beds or over in the United States and Canada. The attached list of hospitals was given a place on the "approved" list.

The asterisk indicates hospitals which have instituted measures which insure scientific medical care to their patients, but which have not realized them to the fullest extent to date.

"The institutions listed proved that they are giving the best of scientific care to their patients," declared Dr. Franklin H. Martin, Director-General of the American College of Surgeons. "Aided by one of the great educational foundations, we have carried on actual visits to hospitals, made by trained medical men who see working conditions as they are. For the first time this year we have surveyed hospitals of 50-bed capacity and up. These institutions, as well as the larger hospitals, show a marked improvement the country over and place Massachusetts in the fore-front of States which are active in medical progress. Massachusetts is to be congratulated on its splendid showing and on the medical men, hospital superintendents, and trustees who have made this advance possible."

Beth Israel Hospital, Boston.
Beverly Hospital, Beverly.
Boston City Hospital, Boston.
Boston Lying-in Hospital, Boston.
Brookton Hospital, Brookton.
*Burbank Hospital, Fitchburg.
Cambridge City Hospital, Cambridge.
Cambridge Hospital, Cambridge.
Carney Hospital, Boston.
Children's Hospital, Boston.
City Hospital, Fall River.
Clinton Hospital, Clinton.
*Cooley-Dickinson Hospital, Northampton.
Farren Memorial Hospital, Montague City.
*Faulkner Hospital, Boston.
Free Hospital for Women, Boston.
*Hart Private Hospital, Brookline.
Holyoke City Hospital, Holyoke.
House of Mercy Hospital, Pittsfield.
House of the Good Samaritan Hospital, Boston.
Infants' Hospital, Boston.
Lawrence General Hospital, Lawrence.
Long Island Hospital, Boston.
Lowell Corporation Hospital, Lowell.
Lowell General Hospital, Lowell.
Lynn Hospital, Lynn.

*Malden Hospital, Malden.
Massachusetts Charitable Eye and Ear Infirmary, Boston.
Massachusetts General Hospital, Boston.
Massachusetts Homeopathic Hospital, Boston.
Memorial Hospital, Worcester.
Mercy Hospital, Springfield.
New England Hospital for Women and Children, Boston.
Newton Hospital, Newton Lower Falls.
*Noble Hospital, Westfield.
North Adams Hospital, North Adams.
Peter Bent Brigham Hospital, Boston.
Providence Hospital, Holyoke.
*Quincy City Hospital, Quincy.
St. Elizabeth's Hospital, Boston.
St. John's Hospital, Lowell.
*St. Luke's Hospital, New Bedford.
St. Vincent's Hospital, Worcester.
Salem Hospital, Salem.
Springfield Hospital, Springfield.
Truesdale Hospital, Fall River.
Union Hospital, Fall River.
*Waltham Hospital, Waltham.
*Wesson Memorial Hospital, Springfield.
Worcester City Hospital, Worcester.

AMERICAN RELIEF ADMINISTRATION.

Moscow, September—Can an anti-typhus serum be discovered in time to check what promises to be one of the worst epidemics of this disease to which Russia has ever been subjected?

In the laboratory of Sakalinesky Epidemic Hospital here Dr. N. Kritch, a woman physician, and Dr. V. Barikan, director of the Moscow Micrological Institute, are working unrelentingly in the hope that they can develop the required anti-bodies to combat the Microbion Typhi Exanthematici which they discovered last spring after six years' work on the etiology of typhus, before winter increases the already high incidence of the disease. Upon the success of their efforts may depend the lives of hundreds of thousands, if not millions, of typhus victims within the coming six months.

For the typhus is not only disseminated throughout Russia to an extent hitherto unknown, but the typhus curve, which usually falls in summer until deaths from the disease are of rare occurrence, and rises in the winter, when lack of bathing facilities and the use of added clothing tends to increase the vermin infestation, has not pursued its usual course. Instead of falling during the summer months it has remained practically level. Last winter the incidence of the disease was abnormally high even for Russia. This summer it has remained high, indicating, in the opinion of both Russian and American physicians who have studied the situation, that the epidemic this winter will be even more severe than that of last year.

In order that they may pursue their researches the American Relief Administration has provided the laboratory where their experiments are being carried on with all the necessary supplies for their work, and in addition has given food packages to the experimenters.

AMERICAN SYNTHETICS.

The Fordney-McCumber Tariff Bill, recently passed by Congress, unfortunately does not provide sufficient protection for American-made medicinal chemicals, nor does it compensate for the extensive research work which has been done by American chemists.

The rates on medicinal chemicals were passed over the protest of the medical profession. It is now possible for the physicians to follow up their protests by using only American-made synthetics, and referring to them at all times by their American names, as suggested by the Council on Pharmacy and Chemistry of the American Medical Association.

Among the important American-made medicinal which should receive the support of all American physicians, are Arsphenamine, Barbitol, Cinchophen and Procaine.

RÉSUMÉ OF COMMUNICABLE DISEASES.

SEPTEMBER, 1922.

General Prevalence.—There was a general increase in the more prevalent communicable diseases for the month. Diseases showing an increase for the month are anterior poliomyelitis, diphtheria, ophthalmia neonatorum, scarlet fever, typhoid fever and whooping cough. Anterior poliomyelitis was reported in 63 cases, against 55 for last month, and 54 for September, 1921. Diphtheria was reported in 578 cases for the month, 481 for August, 1922, and 525 for September, 1921. Ophthalmia neonatorum was reported in 109 cases, against 100 for the previous month. There were 149 cases reported in September, 1921. Scarlet fever was reported in 281 cases, against 208 for the previous month, and 279 for September, 1921. Typhoid fever was reported in 131 cases, against 101 for the previous month, and 124 for September, 1921. Whooping cough was reported in 637 cases, against 483 for the previous month, and 247 for September, 1921.

Chicken-pox was reported in 53 cases, against 60 for the previous month, 61 for September, 1921.

Measles.—During the month 269 cases were reported, against 338 for the previous month, 201 for September, 1921.

Pneumonia, Lobar.—There were 86 cases reported for the month, against 91 for August and 126 for September, 1921.

Tuberculosis, Pulmonary, was reported in 457 cases for the month, against 547 for the previous month, and 512 for September, 1921.

Gonorrhea was reported in 493 cases and *syphilis* in 179 cases.

RARE DISEASES.

Anterior poliomyelitis was reported from Abington, 1; Attleboro, 3; Belmont, 1; Boston, 15; Brockton, 1; Brookline, 1; Cambridge, 2; Clinton, 1; Danvers, 1; Dennis, 1; Eastham, 1; Fall River, 2; Gloucester, 1; Greenfield, 1; Hanover, 1; Lawrence, 2; Lynn, 1; Lynnfield, 1; Malden, 1; Manchester, 1; Marblehead, 1; Medford, 2; Natick, 3; Needham, 1; New Bedford, 2; Northbridge, 1; Peabody, 1; Quincy, 1; Revere, 1; Somerville, 2; Webster, 2; Wellesley, 1; Westport, 1; W. Springfield, 1; Woburn, 2; Worcester, 1; Wrentham, 1; total, 63.

Dog-bite requiring anti-rabic treatment was reported from Billerica, 1; Boston, 3; Chelmsford, 1; Dartmouth, 1; Fall River, 1; Holyoke, 1; Lowell, 8; Warren, 1; Winthrop, 4; total, 21.

Dysentery was reported from Boston, 1.

Encephalitis lethargica was reported from Arlington, 1; Ayer, 1; Boston, 1; Brockton, 1; Lynn, 1; Melrose, 1; Quincy, 1; Taunton, 1; Watertown, 1; total, 9.

Epidemic cerebrospinal meningitis was reported from Boston, 1; Lancaster, 1; Lawrence, 1; Peabody, 1; total, 4.

Hookworm was reported from Boston, 5.

Leprosy was reported from Cambridge, 1.

Malaria was reported from Boston, 2; Hadley, 2; Lowell, 1; Newburyport, 1; Uxbridge, 2; total, 8.

Pellagra was reported from Boston, 2.

Septic sore throat was reported from Boston, 1; Holyoke, 1; total, 2.

Tetanus was reported from Boston, 2; Brockton, 1; Sandwich, 1; Sterling, 1; total, 5.

Trachoma was reported from Acton, 1; Billerica, 1; Boston, 4; Cambridge, 1; Worcester, 1; total, 8.

Trichinosis was reported from Boston, 1.

CENSORS' MEETING.

The Censors for the several districts will meet for the examination of applicants for fellowship on the first Thursday of November.

The Censors for the Suffolk District will examine applicants residing in that district and also applicants who are non-residents of Massachusetts.

Applicants for fellowship should apply to the Secretary of the District Society of the district in which they reside (have a legal residence) at least one week before the date of a given examination, taking with them their degrees in medicine.

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"TIMEO DANAOS ET DONA FERENTES."

Among the various circulars, samples, blotters, and calendars which constitute so large a proportion of every doctor's mail, there recently appeared a 12-page pamphlet entitled "Proprietary Medicines and the Doctor." This treatise was written by Judge Irwin G. Jennings, M.A., Ph.D., who is apparently the Lord High Director of Diplomacy for the Glass Container Association.

Judge Jennings' article is an appeal to the medical profession to co-operate with the proprietary medicine manufacturers. The writer argues that there is no ground for the doctor's hostility towards patent medicines; that the latter no longer contain narcotics or alcohol. He neglects to say that the chief reason they do not contain these, is that the A. M. A. brought about the passage of the Pure Food and Drug Act in order to stop the indiscriminate sale of poisons to the ignorant and the credulous. Proprietary medicines, says Jennings, are more accurately compounded and are cheaper than the same formulae when made up according to a physician's prescription. Their relative cheapness, he continues, enables the poor to have medicine even if they cannot afford a doctor and keeps them from the faker and the quack. (In our experience these two last named gentlemen have no use for the poor anyway.)

Judge Jennings devotes several pages to figures culled from various reports, to prove that many people cannot afford to pay a doctor. No doctor needs proof of this—his own accounts are evidence enough. Jennings' greatest argument for co-operation is based upon his premise that the practice of legitimate medicine is about to go to the wall through the activities of Osteopaths, Chiropractors, et al. If the doctor will only let the manufacturers of proprietary medicine have a free hand, the latter "can easily keep the American public sold to the curative properties of drugs," and by so doing, will force them back into the arms of Regular Medicine.

This ingenuous attempt to persuade the medical profession to be the publicity agent for the proprietary medicine companies is too weak to stand alone. It falls to pieces as you examine it. In the first place, the function of the doctor is not to sell medicine or to prescribe it. His function is to diagnose disease, and, having done so, to take steps to relieve its symptoms or to eradicate its cause. In the accomplishment of these ends, the administration of medicine plays but a small part. The drugs which are of value are few in number and are best given in their simplest and least complicated forms. Narcotics cannot be dispensed except by special prescription. Specific remedies such as quinine in malaria and mercury in syphilis should not be taken unless the disease has first been accurately diagnosed. Cardiac tonics and diuretics should be given only in well-regulated doses under the doctor's guidance. Judge Jennings says that inasmuch as the great majority of human ills are of a general make-up, such remedies, i.e., prescriptions of a general nature, are appropriate and valuable for the purpose. We do not know what he means by this unless it is that the use of the shotgun prescription once so popular but now regarded as poor medicine, is the most economical way of preserving the health. Even those favorites of the patent medicine man, the cough mixtures and the tonics, should not be consumed indiscriminately.

In fact the entire theory of self-diagnosis or of drug clerks' diagnosis, upon one or the other of which the use of patent medicines depends, is most pernicious, and is likely to lead to the neglect of symptoms which are in reality signals of danger ahead. Even if we assume that the proprietary medicines are cheaper than similar formulae privately compounded we cannot regard them as cheaper in the long run. For one thing their composition is unnecessarily complex. If a definite therapeutic effect is desired, it can be secured best by the use of the simple drug and not by the use of a compound in which the action of various substances tend to obscure one another. The poor can get help in hospitals. Even if they do not avail themselves of this opportunity, they would do much better to in-

vest five dollars in one visit to a competent physician than to spend the same amount or probably much more in self-directed experimentation in pharmacology as contained in the patent medicine bottle.

The time has come when as a result of persistent attempts at education, the more intelligent portion of the public has learned to keep away from patent medicine. It would seem as if the vested interests realize the menace which education holds for their business and hope by such efforts as this one of Judge Jennings to regain their grip upon the imagination of the public. If they expect the medical profession to aid them, they are doomed to disappointment.

THE COLLEGE OF SURGEONS—AND BOSTON.

A GLANCE at the programme extraordinary prepared for the visiting surgeons of the present week arouses feelings of amazement, not entirely unmixed with consternation. Apparently every single hour from 9.30 Monday morning to 11.30 Friday night is crammed to overflowing with clinics and conferences, lectures, demonstrations, operations, end-results, registrations and convocations; there are a few brief and fleeting moments left for food and sleep, but for human contact of man to man,—for short intervals during which visitors might glance, if ever so briefly, at many things in Boston, historic, picturesque and more or less medical, there seems to be neither time nor provision. This is, to say the least, unfortunate. But let us hasten to observe that it in no way reflects on Boston hosts, or the physicians of the Hub. It is precisely in the spirit and practice of well nigh all medical meetings in the United States—and based upon the theory that a moment left without formal medical exercises of one or another variety is a moment hopelessly lost.

This view, however, is not held throughout other parts of the world; particularly in Canada, the British Isles, and Central Europe. There the great medical meetings take cognizance of the fact that all work and no play is even worse for adults than for children; there they realize the great and simple truth that the most important element in medical meetings is, literally, in meeting, and talking with, medical men. In direct personal conversation and entirely informal exchange of views, more may often be learned than in listening to lectures, or even attending clinics. This personal contact is both a pleasure and a privilege, and often an inspiration. More time should be permitted for it, and assigned to it. Moreover, the cities in which the annual convocation of the College are held, contain, without exception, features of very great interest to medical men and their families.

In Boston, for example, naming at random

a few of very many things which have, at least remotely, medical aspects, there is:

The Metropolitan Park System—one of the first and finest in the world, of very great importance in relation to the health of the community; a system easily visited, and dotted with memorials of special interest to doctors. One thinks immediately of the Ether Monument, which always brings to mind the well-worn pun; the exedra and sundial upon the Charles River Esplanade, directly in the rear of 298 Beacon Street, bearing the dedication to the poet whose library overlooked it—and the lines from one of his most graceful songs:

"Love dies not when he bows his head
To pass beneath these darkened Portals."

And speaking of Dr. Oliver Wendell Holmes, let it not be forgotten that the actual physical inspiration which resulted in the most beautiful of his verses, the shell which caused him to sing of "The Chambered Nautilus," rests in a cabinet in the Boston Medical Library, in the hall so appropriately named for him.

Adjoining it, in Holmes Hall, is the unique collection of medals acquired by the late Dr. Horatio Storer, who died only a few days ago at Newport. Dr. Storer was at once Harvard's oldest living graduate and one of America's greatest physicians. This collection is by far the most important and the largest in the world, and has been catalogued and arranged by Dr. Malcolm Storer, who, like his father, is an eminent numismatologist.

In the park surrounding Bunker Hill Monument stands the simple granite stone which marks the spot where General Joseph Warren fell—a skilful physician whose name has for 150 years been held highly by five generations of medical men.

Where but in Boston could a doctor say to a companion: "Do you see that gentleman across the street? I cut that man; my father cut his father; my grandfather cut his grandfather?"

How many Bostonians or visitors, as they leave the South Station, realize that the spot from which the "Indians" embarked for the greatest of all afternoon teas is diagonally across Atlantic Avenue on the corner of Pearl Street, and properly marked by tablet and verse? It is credibly believed that among those Boston Indians at least one Boston surgeon brandished, not inappropriately, a knife, and perhaps a tomahawk. How many remember, by walking further along the avenue, one may stand on the very spot upon which the undefeated frigate, the Constitution, was built and launched, and from which she set sail; and that looking northwest by north from this spot we still may see the frigate herself—with lofty mast, and powerful spars, just as in 1813, lying quietly at the Navy Yard in Charlestown?

Perhaps it may be a trifle lacking in humor to call the attention of surgeons to graveyards—

but graveyards are parks and precious spots in Boston, and of interest to everyone who reveres the worthy dead. A visit to Copp's Hill burying ground, above the picturesque granite terrace almost opposite Constitution Wharf, becomes a visit of very great interest, both for what may be seen in the yard and for what may be seen from it; it is literally on a hilltop. And in the Old Granary graveyard the surgeon may see the gravestone of Dr. John Jeffries, of gentle memory, next to that of his townsman, Paul Revere, and close to the granite pyramid which the youngest son, Benjamin, raised to his parents, the elder Franklins, and upon which he caused to be placed so admirable an epitaph.

And if the visitors will stray as far afield as Cambridge they may well go "for to admire and for to see" that really beautiful burying ground at Mount Auburn, which was conceived and planned and made possible by Boston's greatest surgeon; in whose name the great golden medal was last night so appropriately bestowed upon his friend, another great American surgeon—Bigelow and Keen, great men, as well as great doctors.

Of course, every visitor should go and worship in the old amphitheatre, high in the rounded dome of the Bulfinch Building at the Massachusetts General Hospital—and gaze reverently about him, upon the room which looks now just as it did on the day when within its walls general anesthesia was first given by American doctors to a suffering world. And they may also look with great interest at the small tablet over the narrow door on Tremont Street, near Pemberton Square, which marks the building in which nitrous oxide gas was first deliberately administered in operative dentistry.

Coming down Tremont Street, let them turn into West and thence to Mason, and glance at the first building ever erected for the Harvard Medical School: a substantial brick structure in which the original lines may still be discerned, notwithstanding that Boston has taken the building and so changed it that it has become as good a fire engine station as it once was a medical school—and for both one of the best in the country.

On Washington Street, opposite Boylston, there stands at present a substantial store within which excellent rugs and carpets may be purchased. Years ago and for many years, good Bostonians purchased equally excellent pastry at this spot: it is also written that the original proprietor and his nephew increased their profits by cutting their pies into *five* quarters, instead of into four; and they still gave more, and better, at the old tariff, than can now be obtained for three times as much: from this simple and apparently unimportant episode—and due largely to it—came two great hospitals to Boston; and to Boston now come medical men from the ends of the earth, to see the work which is done in these institutions. Truly some

substantial gains accrue to those who live in the Great Pie Belt!

Every surgeon coming to Boston should see the Crow Bar, and the Crow Bar Skull, as well as the rest of the great collection in the Warren Museum, three flights up in the Administration Building of the Harvard Medical School; and stand before the case which contains the skeleton of a benefactor of the museum, which, by the provisions of his will, is annually visited and inspected by grave and reverend seniors. Incidentally, if he goes to that school as he should, on foot up through Avenue Louis Pasteur, he may look upon public schools, palaces, academies, hospitals large and small, and many great white laboratories, as many and as fine as may be found in all the world—a singular contrast, indeed, to the old brick fire station in Mason Street.

This list might be extended obviously and indefinitely: no attempt is made to do more than suggest a very small part of the objects and places that might be visited by those interested. Of course, the Public Library and Art Museum may be taken for granted. But none of these things can be done without time—and no time is allowed by the programme; nor, indeed, are such medical and pious pilgrimages even suggested.

Let it be remembered also that the other cities in which the Congress has held convocation, and I will yet hold them, have spots and objects equally interesting as those in Boston. New York, Philadelphia, Baltimore, Washington, Chicago and many other places are rich in matters often essentially medical, sometimes partly so and occasionally not at all surgically related, but well worth visit and contemplation by any man who holds the highest ideal of the physician before him as his model.

Would it not be possible to begin clinics at 8.30 A. M., carry them on until 12.30 P. M., begin again at 1 and end at 3 P. M., and then let the doctors, their wives and their friends take a few long breaths of fresh air, and look at some of the other things that make life so well worth living in Boston, and in America!

News Notes.

TUFTS COLLEGE MEDICAL AND DENTAL SCHOOLS.—Medical Registration for the Session of 1922-1923: 1st year, 145; 2nd year, 127; 3rd year, 144; 4th year, 61. Pre-Medical Registration: 1st year, 179; 2nd year, 107. Dental Registration for the Session of 1922-1923: 1st year, 42; 2nd year, 46; 3rd year, 156; 4th year, 127. Pre-Dental Registration: One year, 128.

Dr. Andrew W. Ryan, who has been for several years engaged in industrial research in physiology, has returned to active teaching as Professor of Physiology.

Dr. Benjamin Spector, Assistant Professor of

Anatomy, comes to Tufts from Cornell Medical School, where he taught last year.

DEATH RATE IN BOSTON.—During the week ending October 21, 1922, the number of deaths reported was 204, against 173 last year, with a rate of 13.93. There were 36 deaths under one year of age, against 21 last year. The number of cases of principal reportable diseases were: Diphtheria, 62; Scarlet Fever, 23; Measles, 25; Whooping Cough, 30; Typhoid Fever, 4; Tuberculosis, 45. Included in the above, were the following cases of non-residents: Diphtheria, 12; Scarlet Fever, 6; Typhoid Fever, 3; Tuberculosis, 5. Total deaths from these diseases were: Diphtheria, 4; Tuberculosis, 11. Included in the above, were the following cases of non-residents: Diphtheria, 1; Tuberculosis, 2.

BEVERLY HOSPITAL.—The following is the program of the demonstration clinic held at the Beverly Hospital October 17th:

Fistula in ano. Tumor of the abdomen. Pneumonia. Pneumonia. Fever unexplained. Acute gangrenous cholecystitis. Acute hemorrhagic pancreatitis.

THE JOINT MEETING AT TEWKSBURY.—A joint meeting of Middlesex North, Middlesex East, Essex North and South was held at the State Institution, Tewksbury, on Wednesday, Oct. 18, 1922, with about 200 members in attendance. The visiting members were received by the Superintendent, Dr. John Holyoke Nichols, who, with his corps of assistants, conducted the party in groups about the institution. At 3:30 p. m. all gathered in the chapel, where the meeting was held.

Dr. J. W. Bartol, the President of the parent society, spoke of the reciprocal relation of the society and the individual component units and asked that suggestions be made to the Council as to the various activities of the society. Dr. C. F. Painter discussed some of the problems connected with the duties of the Board of Registration in Medicine and referred to some recently attempted legislation in this connection.

Dr. James S. Stone presented for the consideration of the members several alternative propositions for dealing with the situation arising as a result of complaints concerning certain of the smaller hospitals which have been housing obstetric cases and others which have had the care of insane persons.

Dr. Henry Jackson delivered an address upon Diseases of the Myocardium, illustrating the value of the polygraph and electrocardiograph in diagnosis and prognosis.

Dr. J. H. Nichols gave some interesting and instructive statistics of the infirmary covering his thirty years' connection with the institution.

It was voted unanimously that a similar joint meeting should be an annual feature of the program of the four district societies represented.

Mr. Conant, chairman of the Commissioners of Public Welfare, welcomed the society and voiced a tribute to the efficiency and enthusiasm of the Superintendent, Dr. Nichols.

Dr. Anthony, one of the trustees, spoke of the quality and great variety of professional work accomplished at Tewksbury.

A vote of thanks was extended to the speakers of the afternoon and to Dr. Nichols for his hospitality.

Adjournment at 5:30 was followed by an excellent dinner. William H. Hopkins, M.D.,

Reporter.

BERKSHIRE DISTRICT MEDICAL SOCIETY.—A meeting of the Berkshire District Medical Society was held at the Richmond Hotel, North Adams, on Thursday evening, October 26th, 1922. Dr. Charles M. Williams, Professor of Diseases of the Skin at the Post Graduate Medical School of New York City, gave a practical talk on the diagnosis and treatment of the more common diseases of the skin, with illustrations.

AT THE MEETING OF THE AMERICAN COLLEGE OF SURGEONS Dr. I. S. F. Dodd, Dr. J. B. Thomes, Dr. B. W. Paddock and Dr. T. P. Hennelly were initiated as Fellows of the College, all residents of Pittsfield.

Directly following this meeting Dr. Thomes and his wife went to Maine, where they will remain for about a month.

The wife of Dr. Louis Barnes of Lanesborough is confined to the House of Mercy Hospital in Pittsfield, following an operation recently performed.

Dr. John J. Boland of Pittsfield has returned to his practice after a visit to New York clinics.

THE MEETING OF THE SUFFOLK DISTRICT MEDICAL SOCIETY.—At the meeting of the Suffolk District Medical Society on Wednesday evening, October 18, an enthusiastic audience, which filled Ware Hall, greeted Dr. John O. Polak, professor of obstetrics in the Long Island College Hospital.

Dr. Polak stated that the title of his address should in reality be "A Plea for Safe Obstetrics." He pointed out the relatively small number of operations in obstetrics which were necessary in a large obstetric service such as he conducts, and he showed that the number of Caesarean sections which he found necessary corresponded very closely with those found necessary in the Johns Hopkins Hospital: about one in 120 cases. He then pointed out the absolute and relative indications for Caesarean section and finally emphasized that there is today too much operating in obstetrics; that Caesarean section is not safe; that unnecessary operations are done, and that, all in all, both the morbidity

and mortality are much higher than in regular abdominal sections; and that, furthermore, Caesarean sections are by no means devoid of risk to the child.

The paper was discussed by Dr. Newell, Dr. DeNormandie, Dr. Ruggles, Dr. Friedman, Dr. Mongan and Dr. Donoghue.

Dr. Donoghue very pertinently pointed out that outside of the large cities there is a scarcity of men trained in obstetric work, and that therefore surgeons were called in who did Caesarean sections where trained obstetricians might deliver by other methods. Dr. Mongan made an earnest plea for the coöperation of all members of the Society with the new Section on Obstetrics in the Massachusetts Medical Society.

THE BOSTON DISPENSARY.—The October meeting of the Medical Staff of the Boston Dispensary was held on Wednesday, October 11th, in the rooms of the Medical Department. Dr. William E. Preble, Physician-in-Chief of the Medical Department, read a paper, "Observations on 1,000 Cases of Obesity," 700 of which were taken from his own records, and 300 from the records of the Boston Dispensary. Charts showing the incidence of high blood pressure, diabetes, nephritis, heart disease, and other conditions, among these 1,000 cases, were also shown.

HARVARD MEDICAL SCHOOL.

At a meeting of the President and Fellows of Harvard College in Boston, October 9, 1922, it was voted to appoint them: Abbott Lawrence of the Boylston Medical Committee:

Dr. Reid Hunt, Secretary, Drs. William T. Porter, Robert W. Lovett, Henry A. Christian, John Warren and Henry Lyman.

The resignation of Lawrence Weld Smith as Instructor in Pathology was received and accepted, to take effect September 1, 1922.

The President nominated the following persons as members of the Administrative Board of the Medical School for the year 1922-23, and it was voted to appoint them: Abbott Lawrence Lowell, ex-officio; David Linn Edsall, ex-officio, Chairman; Algernon Coolidge, Milton Joseph Rosenau, Harvey Cushing, Reid Hunt, John Lewis Bremer, Walter Bradford Cannon, Charles Macfie Campbell, Worth Hale, Simeon Bert Wolbach, Oscar Menderson Schloss, Francis Weld Peabody.

(Consented to by the Board of Overseers at their meeting of October 9, 1922.)

Voted to make the following appointments for one year from September 1, 1922: *Instructors*—Zabdiel Boylston Adams in Orthopedic Surgery, Henry Ingersoll Bowditch in Pediatrics, Lloyd Thornton Brown in Orthopedic

Surgery, Michael Joseph Conroy in Pathology, Louis Riley Daniels in The Practice of Industrial Medicine, Henry Joseph FitzSimmons in Orthopedic Surgery, Otto John Hermann in Surgery, Daniel Fiske Jones in Surgery, Arthur Thornton Legg in Orthopedic Surgery, Halsey Beach Loder in Surgery, Richard Henry Miller in Surgery, Frank Roberts Ober in Orthopedic Surgery, Channing Chamberlain Simmons in Surgery, Marius Nygaard Smith-Petersen in Orthopedic Surgery, Robert Soutter in Orthopedic Surgery, Philip Haskell Sylvester in Pediatrics, Wyman Whittimore in Surgery, Edward Theodore Wyman in Pediatrics.

Assistants.—Percival Bailey in Surgery, William Bradley Breed in Medicine, Albert Howell Brewster in Orthopedic Surgery, Trevor Goff Browne in Pathology, Thomas Ellwood Buckman in Pediatrics, Edward Delos Churchill in Surgery, Bronson Crothers in Pediatrics, Robert Dudley Curtis in Pediatrics, Robert Ogden Dubois in Pediatrics, Paul Waldo Emerson in Pediatrics, Martin Joseph English in Pediatrics, Richard Spelman Eustis in Pediatrics, Ralph Ghormley in Orthopedic Surgery, Frederic Leo Good in Gynecology, Hyman Green in Pediatrics, Francis Browne Grinnell in Bacteriology and Pediatrics, Louis Webb Hill in Pediatrics, Harold Valmore Hyde in Anatomy, Henry Jackson, Jr., in Medicine, Carl Edward Johnson in Comparative Anatomy, Robert Joseph Kirkwood in Pathology, Arthur Bates Lyon in Pediatrics, Arthur Rolan Newsom in Pediatrics, Derrie Choate Parmenter in Industrial Medicine, Monroe Jacob Schlesinger in Pathology, Warren Richard Sisson in Pediatrics, Harold Wentworth Stevens in Industrial Medicine, Harry Weiss in Bacteriology, Philip Duncan Wilson in Orthopedic Surgery.

William Charles Boeck, Research Fellow in Comparative Pathology; Selig Hecht, Research Fellow in Physical Chemistry; Charles Carroll Lund, Alumni Assistant in Surgery; Joseph William Schereschewsky, Associate in Preventive Medicine and Hygiene; William Justus Merle Scott, Arthur Tracy Cabot Fellow in charge of Laboratory of Surgical Research.

At a meeting of the President and Fellows of Harvard College in Cambridge, June 21, 1922, it was voted to proceed to the election of a Professor of Orthopedic Surgery, to serve from September 1, 1922: Whereupon, ballots being given in, it appeared that Robert Bayley Osgood was elected.

This election carries with it the position as chief of the orthopedic service at the Boston Children's Hospital. Dr. Osgood has, accordingly, been appointed visiting surgeon and head of the orthopedic service at the Children's Hospital in place of Dr. R. W. Lovett, whose resignation has been accepted. Dr. Osgood will assume his new duties at once.

THE BESTOWAL OF THE HENRY J. BIGELOW MEDAL TO DR. KEEN.

A SIMPLE recital of the exercises in Jordan Hall on the evening of October twenty-fifth, even with the copy of Dr. William Williams Keen's address, as published in the JOURNAL of October twenty-sixth, can never convey to those not privileged to be present an adequate appreciation of the dignity of that occasion. The graceful introduction by Dr. Robert W. Lovett, followed by the address of Dr. Keen, delivered with enthusiasm which would have been remarkable in a much younger man, thrilled the audience.

The introduction and the address were recorded in the pages of a previous issue of this JOURNAL, and in completion of the program we now have the honor of publishing the presentation speech of Dr. Harvey Cushing, which will stand as a fitting tribute to the preëminent standing of Dr. Keen as a surgeon, and a gentleman whose life has been devoted to humanity.



(Dr. Cushing's Speech)

DR. KEEN: From time to time, to an individual, "for conspicuous contributions to the advancement of surgery," the Boston Surgical Society awards a gold medal bearing the name and presentment of a man once a great figure in our profession.

This Society has decided on this occasion to make its award not to an individual but to an institution incorporated with unbounded enthusiasm over half a century ago.

The institution to which I refer has been distinguished from the outset for its patriotism; and its first official act as long ago as 1861 was the loan to the Fifth Massachusetts Regiment, and so to the Nation, of an assistant surgeon.

Soon after it came into existence, the same institution established an editorial and publishing bureau, and since the first appearance in print in 1864 of a medical classic entitled "Gun-shot Wounds and Other Injuries of the Nerves," there has followed a series of essays, monographs and volumes of no less interest and importance.

It has given to the profession a succession of teachers in anatomy and surgery in more than one school of medicine—demonstrators, lecturers, professors, and even a professor emeritus—so that its pupils have been legion.

When that most unpromising of all specialties, the surgery of the nervous system, needed an optimistic pioneer, it was called upon to furnish one.

It has provided a most active and courageous champion against the opponents and slanderers of the experimental method in the medical sciences.

It has also provided a series of Fellows, of Trustees, even of Presidents for many scientific, learned and professional bodies at home and abroad—one of them a society founded by our common, though not quite contemporary fellow townsman, the equally many-sided Benjamin Franklin.

It was once said by Horace Greeley that "fame is a vapor, popularity an accident, riches take wings, those who cheer today will curse tomorrow; only one thing endures, and that is character."

Accordingly to you, Sir, to you as an American institution, to you who already stand knee-deep in honors, in all affection and with all humbleness, in the name of the Boston Surgical Society, and by its direction, I present still another award, the Henry Jacob Bigelow Medal, highly deserved not only for your accomplishments and services to medicine, but for that which means more than these—for that more enduring quality—your professional character.

Dr. Keen then thanked the Society for the honor conferred. Dr. Lovett then closed the meeting.

PROGRAMS FOR HOSPITAL CLINICS DURING CANCER WEEK. NOV. 12 TO 18, 1922.

CARNEY HOSPITAL.

Monday, November 13, 1922,
9:30 A. M.

Gynecological Operations and Demonstrations of End-Results: Dr. F. W. Johnson and Dr. L. E. Planteuf.

Surgical Operations and Demonstrations of End-Results: Dr. J. T. Bottomley, Dr. D. F. Mahoney and Dr. A. McK. Fraser.

THE PETER BENT BRIGHAM HOSPITAL.

AMPHITHEATRE, OPERATING BUILDING,
10 A. M. to 12 M.,

Tuesday, November 14, 1922.

The Pathology of Malignant Disease in Relation to Age: Dr. Wolbach.

The Treatment of Malignant Disease of the Prostate and Bladder: Dr. Quinby.

Malignant Disease of the Central Nervous System: Dr. Cushing.

Symptomatology of Cancer of the Alimentary Tract and Its Operability: Mouth to Pylorus: Dr. Cheever. Large Intestine and Rectum: Dr. Homans.

Recent Advances in the X-Ray Treatment of Malignant Disease: Dr. Sosman.

OPERATIVE CLINIC DURING THE MORNING.

COLLIS P. HUNTINGTON MEMORIAL HOSPITAL.

Tuesday, November 13, 1922,
2:30 P. M.

The Cancer Commission of Harvard University.

Dr. R. B. Greenough.

Radium in the Treatment of Disease,

Dr. William Duane.

Cancer of the Skin,

Dr. L. S. McKittick.

The State Free Diagnosis Service,

Dr. J. H. Wright.

Cancer of the Buccal Cavity,

Dr. C. C. Simmons.

Cancer of the Uterus,

Dr. G. A. Leland, Jr.

Laboratory Work in Bio-Physics,

Dr. W. T. Bovie.

Radium in the Treatment of Leukaemia,

Dr. G. E. Minot.

Radium in the Treatment of Cancer of the Genito-

Urinary Organs,

Dr. G. G. Smith.

The Treatment of Cancer of the Nose, Throat and

Accessory Sinuses,

Dr. D. C. Greene.

THE BOSTON DISPENSARY.

Thursday, November 16, 1922,
11:00 A. M. to 1:00 P. M.

1. Medical Department: Dr. William E. Preble and Associates: Demonstration showing cases and illustrating methods of diagnosis, particularly cancer in the gastro-intestinal tract.

2. Dermatological Department: Dr. Henry J. Perry: Cancer of the Skin and Its Treatment by Radium.

3. Surgical Department: Dr. Hilbert F. Day.

4. Laboratory Department: Demonstration of Specimens and Slides: Dr. William A. Hinton.

The Dispensary will also offer a Free Clinic on Thursday, November 16th, on which day patients having or fearing they have cancer may come for examination without charge.

MASSACHUSETTS GENERAL HOSPITAL.

SURGICAL AMPHITHEATRE.

Friday, November 17, 1922,
10 A. M.

10:00—The Control of Cancer: Dr. R. B. Greenough.

10:15—Cancer of the Skin: Dr. C. J. White.

10:30—Cancer of the Lip and Mouth: Dr. C. C. Simmons.

10:45—Cancer of the Nose and Throat: Dr. D. C. Greene.

11:00—Cancer of the Stomach: Dr. C. L. Scudder.

11:15—Cancer of the Colon and Rectum: Dr. E. P. Richardson, Dr. L. S. McKittick.

11:30—Cancer of the Breast: Dr. R. B. Greenough.

11:45—Cancer of the Uterus: Dr. Lincoln Davis.

12:00—Cancer of the Genito-Urinary Organs: Dr. J. D. Barney.

12:15—The X-Ray Therapy of Cancer: Dr. G. W. Holmes.

BOSTON CITY HOSPITAL.

CHEEVER SURGICAL AMPHITHEATRE.

Saturday, November 18, 1922,
10:30 A. M. to 12 M.

In cooperation with the Cancer Week Campaign of the American Society for the Control of Cancer, the following symposium will be held in the Cheever Surgical Amphitheatre. Physicians, students and nurses are welcome.

The Pathologist's Conception of Cancer: Dr. F. B. Mallory.

Early Recognition of Uterine Cancer: Dr. R. M. Green.

Röntgen Differentiation of Gastric Malignancy and Chronic Ulcer: Dr. F. P. Butler.

Premalignant and Early Malignant Skin Lesions: Dr. T. W. Thorndike.

Symptoms Suggesting Concealed Malignancy: Dr. R. C. Larrabee.

Detection of Malignancy of the Genito-Urinary Tract: Dr. H. H. Howard.

Radium and X-Ray: Indication for Their Use: Dr. Herman Osgood.

Surgical Procedures for Removal of Malignant Growths: Dr. Halsey Loder.

Correspondence.

ERRATUM.

Oct. 23, 1922.

Mr. Editor:

My attention has been called to the fact that, through a misunderstanding, I have made an error in my article on "An Investigation of the Reliability of Laboratory Tests, Etc.," recently published in your Journal. In Part I, I stated in relation to Dr. L. S. Medalla's work: "On his request typewritten copies of the technique in use were submitted from the Boston Health Department Laboratory, the State Health Department Diagnostic Laboratory, the State Wassermann Laboratory and from the Board of Health Laboratories in Brookline, Cambridge, and Somerville." Instead, it should have been stated that he visited each of these laboratories and by questions and observations obtained information concerning the technique in use. This information he had typewritten and submitted to the various laboratories for approval; so that these data were gathered at considerable expenditure of time and effort on Dr. Medalla's part.

I will be grateful if you will publish this correction.

Very truly yours,

F. H. SLACK, M.D.

EASTERN HAMPDEN MEDICAL ASSOCIATION.

The Eastern Hampden Medical Association will meet at the Hotel Bridgeway, Springfield, Thursday, Nov. 2, at 4.30 p.m. Theme: "Tuberculosis." Speakers: Drs. H. B. Perry, S. D. Rumrill, F. H. Smith, C. J. Spauld, G. L. Woods. E. Y. Myers, M.D., Sec'y.

DR. W. W. KEEN'S ADDRESS ON THE OCCASION OF THE BESTOWAL OF THE BIGELOW MEDAL.

This valuable and interesting contribution to medical literature should be read by every physician and surgeon. A few copies are available and may be secured by applying to the BOSTON MEDICAL AND SURGICAL JOURNAL.

THE MASSACHUSETTS MEDICAL SOCIETY.

JOINT MEETING OF THE BARNSTABLE, BRISTOL NORTH, BRISTOL SOUTH, AND PLYMOUTH DISTRICT SOCIETIES.—The meeting will be held at the Lakeville State Sanatorium, Thursday, Nov. 9, 1922. Luncheon will be served at 1.00 P.M. Program at 2.30 P.M. Speakers: Dr. John W. Bartol, President of the Massachusetts Medical Society; George Chandler Whipple, S.B., Professor of Sanitary Engineering, Harvard University, "Mosquito Control in Massachusetts"; Dr. Eugene R. Kelley, Commissioner of Public Health, Commonwealth of Massachusetts; Benjamin White, Ph.D., Director, Division of Biological Laboratories, Massachusetts Department of Public Health, "The Schick Test" (A Schick demonstration will be given at the conclusion of the program.); Dr. Richard P. Strong, Professor of Tropical Medicine, Harvard Medical School, "The Gorgias Memorial Institute." All fellows of the combined district societies are cordially invited to be present at this meeting.

STUMMER COOLIDGE, M.D., President.

ARTHUR R. CRANDELL, M.D., Secretary.

DISEASES REPORTED TO MASSACHUSETTS DEPARTMENT OF PUBLIC HEALTH.

WEEK ENDING OCTOBER 21, 1922.

Disease.	Cases.	Disease.	Cases.
Anterior poliomyelitis	6	Ophthalmia neonatorum	12
Chicken-pox	60	Pellagra	1
Diphtheria	236	Pneumonia, lobar	49
Dog-bite requiring anti-rabic treatment	10	Scarlet fever	112
Encephalitis lethargica	2	Septic sore throat	2
Epidemic cerebrospinal meningitis	2	Syphilis	32
Epidemic cerebrospinal meningitis	1	Suppurative conjunctivitis	6
German measles	2	Tetanus	3
Gonorrhea	133	Tuberculosis, pulmonary	110
Influenza	3	Tuberculosis, other	
Mumps	39	forms	14
Measles	139	Typhoid fever	12
		Whooping-cough	161

ERRATA.

In the article in this issue under the title "New England Hospital Association," on p. 627, under cross infection rate, the figures 63, for the year 1912, should be 6.3, and 17, for the year 1913, should be 1.7.

SOCIETY MEETINGS.

DISTRICT SOCIETIES.

A list of society meetings is herewith published. This list will be changed on information furnished by the secretaries of the societies, and will appear in each issue.

Barnstable District:—Hyannis,—November 3, 1922, February 2, 1923. (Annual Meeting)—May 4, 1923.

Bristol South District:—Fall River,—November 2, 1922, May 3, 1923.

Essex North District:—Haverhill, (Semi-Annual Meeting)—Jan. 8, 1923. Y. M. C. A. Building, Lawrence, (Annual Meeting)—May 2, 1923.

Suffolk District:—Combined meeting of Boston Medical Library and Suffolk District, November 22, 1922; December 27, 1922; January 31, 1923; February 28, 1923; March 28, 1923; Annual Meeting, April 25, 1923.

The Springfield Academy of Medicine meets the second Tuesday of each month. Schedule of speakers includes the following names: Dr. Alexis Carrel, Dr. W. B. Long, Dr. J. W. Williams, Dr. W. S. Thayer, and Dr. Barton Cooke, Hist. The date for each speaker has not been assigned.

Middlesex North District:—Meetings: Wednesday, January 31, 1923.

Worcester District meetings in Worcester, Nov. 8, Dec. 13, 1922, Jan. 10, Feb. 14, March 14, April 11 and May 9, 1923, the last named date being the annual meeting.

A joint meeting of the Plymouth, Bristol North, Bristol South and Barnstable Districts will be held at Lakeville Sanatorium, Middleboro, on November 9, 1922.

STATE, INTERSTATE AND NATIONAL SOCIETIES.

November, 1922. Massachusetts Society of Examining Physicians. (Date and place of meeting undecided), Hilbert F. Day, Secretary. National Cancer Week, November 12 to 18.

December, 1922. New England Dermatological Society Meeting, Wednesday, December 13, 1922, at 3.30 P.M., in the Surgical Amphitheatre, Boston City Hospital, C. Guy Lane, Secretary.

January, 1923. Massachusetts Society of Examining Physicians. (Date and place undecided), Hilbert F. Day, Secretary. Massachusetts Association of Boards of Health, January 25, Annual Meeting, Boston, W. H. Allen, Mansfield, Mass., Secretary.

February, 1923. New England Dermatological Society Meeting, February 14, 1923, at 3.30 P.M., in the Skin Out-Patient Department, Massachusetts General Hospital, C. Guy Lane, Secretary.

March, 1923. Massachusetts Society of Examining Physicians. (Date and place undecided), Hilbert F. Day, Secretary.

April, 1923. New England Dermatological Society Meeting, April 11, 1923, at 3.30 P.M., in the Surgical Amphitheatre, Boston City Hospital, C. Guy Lane, Secretary. Massachusetts Association of Boards of Health, April 26, 1923, Boston, W. H. Allen, Mansfield, Mass., Secretary.

May, 1923. Massachusetts Society of Examining Physicians. (Date and place undecided). American Pediatric Society Meeting, May 31, June 1 and 2, 1923, at French Lick Springs Hotel, French Lick, Ind., H. C. Carpenter, Secretary.

June, 1923. American Medical Association, San Francisco, June 25-29, 1923, Alexander R. Craig, Chicago, Ill., Secretary.

July, 1923. Massachusetts Association of Boards of Health, July 26, Nantasket, W. H. Allen, Mansfield, Mass., Secretary.

*Deceased Sept. 2, 1922.

The Massachusetts Medical Society

OFFICERS ELECTED BY THE COUNCIL JUNE 13, 1923

1922-1923

PRESIDENT

JOHN W. BARTOL, 3 Chestnut Street, Boston, 9.

VICE-PRESIDENT

CHARLES E. MORGAN, 24 Central St., Somerville

SECRETARY

WALTER L. MURRAGE,
42 Eliot Street, Jamaica Plain, 30

TREASURER

ARTHUR K. STONE,
Auburn Street, Framingham Center.

LIBRARIAN EMERITUS

EDWIN H. BRIGHAM,
Brookline; Office, 8 The Fenway, Boston, 17.

NOTICE TO THE FELLOWS OF THE MASSACHUSETTS MEDICAL SOCIETY.

CHANGES OF ADDRESS.

In view of the action of the Council, February 1, 1923, in advancing Librarian E. H. Brigham to the honorable position of Librarian Emeritus, after a continuous service of thirty-seven years, in future, all communications as to membership, especially changes of residence and address, should be sent to the Secretary of the Society, who keeps a constantly corrected official list of the Fellows and their addresses.